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- *Audio-visual Aids in Teaching*
- *Extension Course in Medical Records*
- *Medical Internship—Education or Service*

February, 1953

Official Journal—Canadian Hospital Council

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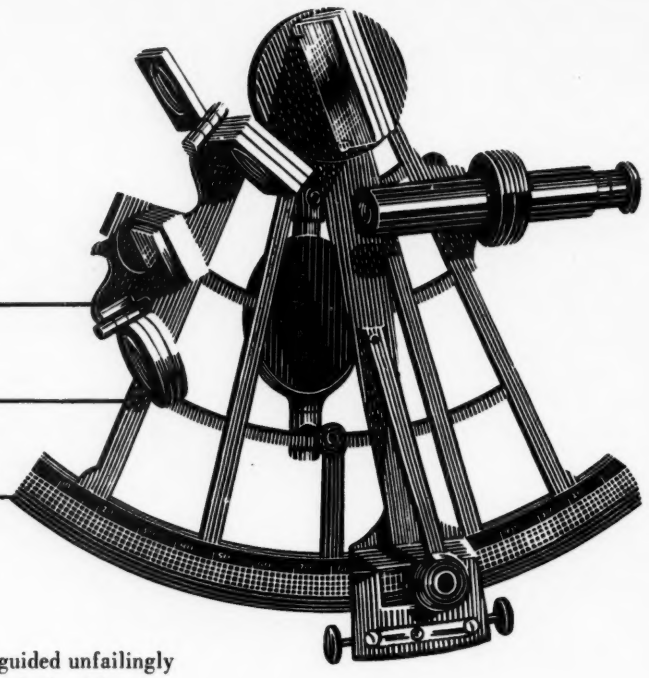

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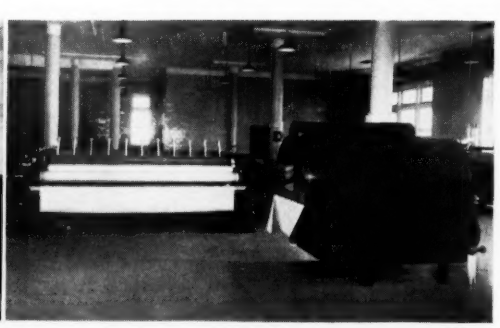

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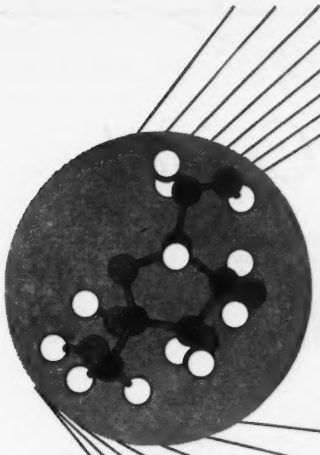

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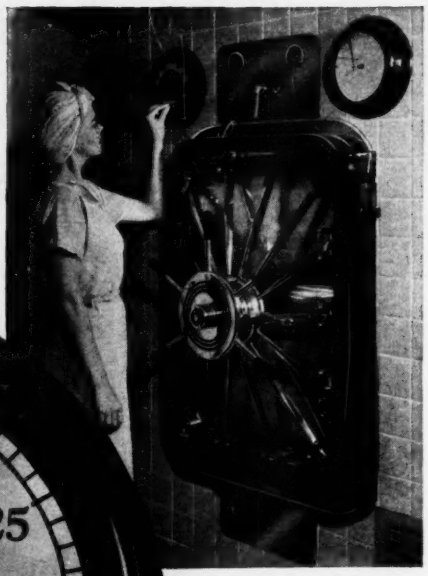

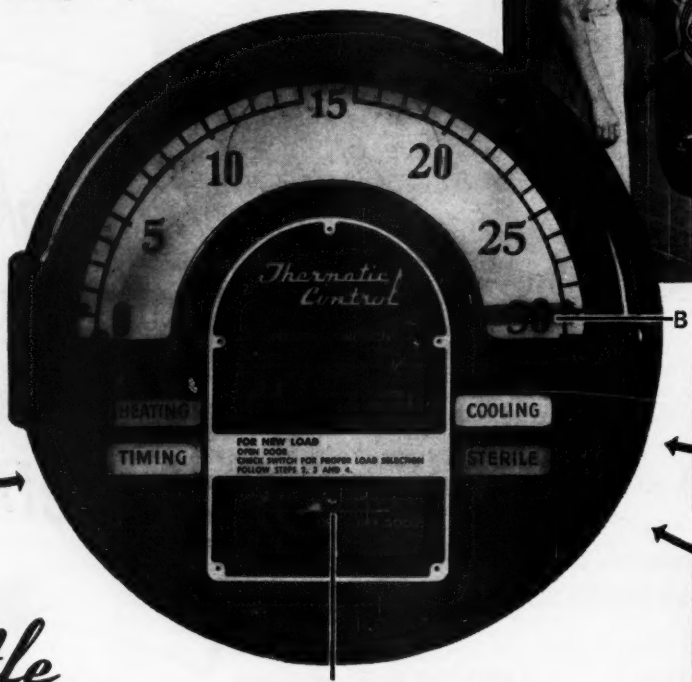

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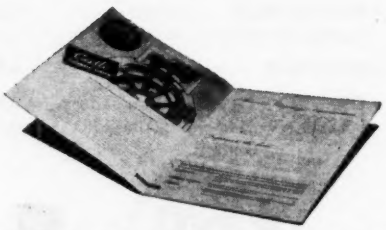

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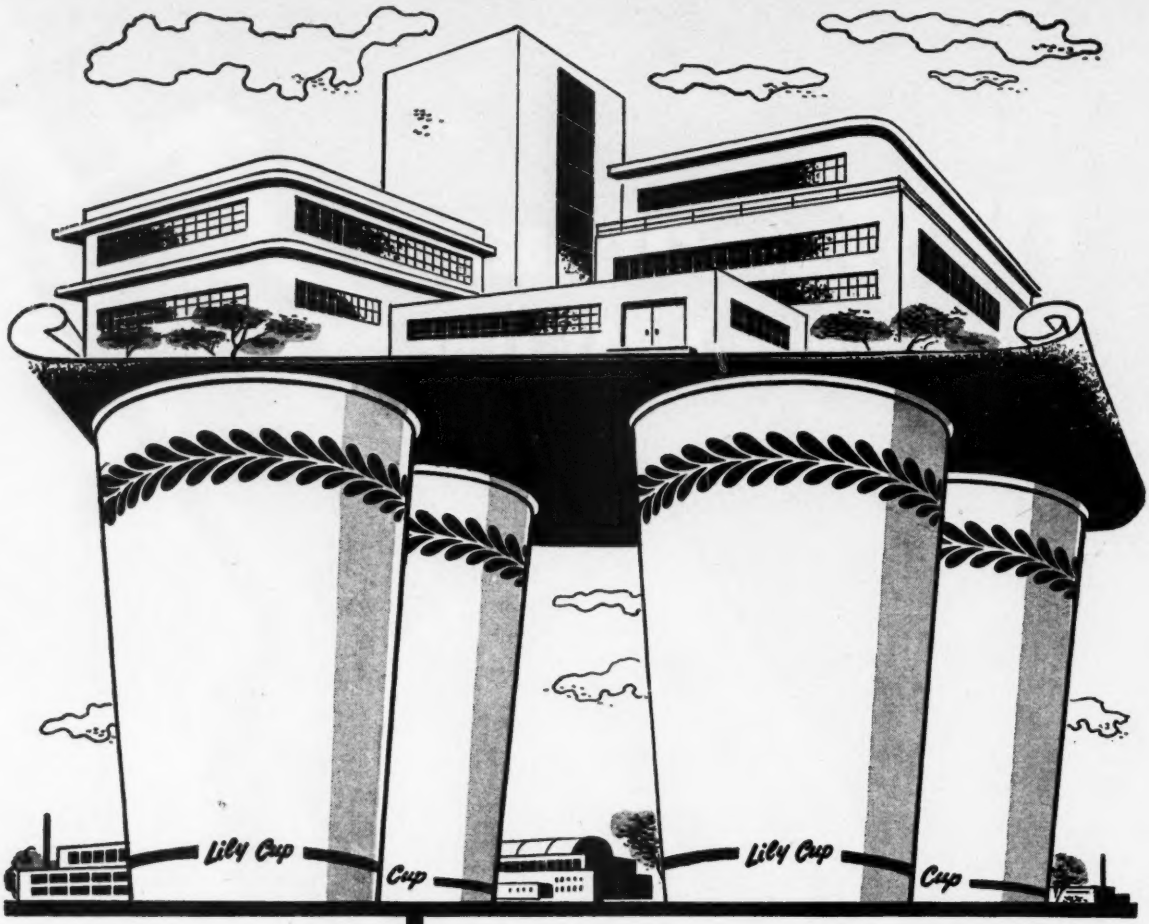

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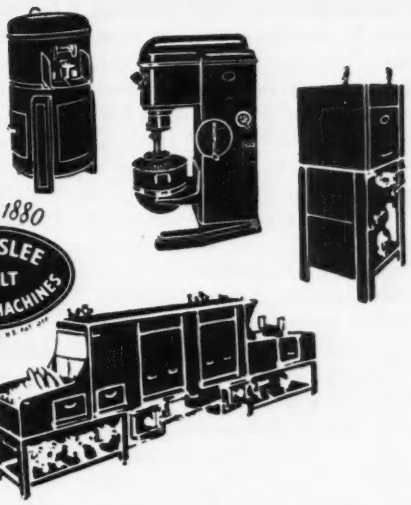

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Notes on Federal Grants

Construction

More than $119,000 has been awarded to three hospitals in Alberta to help cover costs of construction. At the Central Alberta Sanatorium, near Calgary, a new administration building is being built, which will have accommodation for 15 additional patients on the second floor. The federal grant will be $22,500. The Provincial Mental Institute, Oliver, is being enlarged to accommodate 196 more patients. The new wing will be used to care for mental patients with tuberculosis. A federal grant of about $58,200 will be allotted toward this construction work. As the sanatorium at Calgary and the mental institute at Oliver are both provincially-owned, all costs not covered by the federal grants will be met by the province.

At Brooks, Alta., the municipal hospital, which serves about 10,000 people, is being more than doubled in size by the addition of 33 beds for paediatric, medical, obstetrical, and surgical patients, and a 13-bassinet nursery. The federal and provincial governments are each contributing more than $38,300 toward construction costs. Work on the new wing is scheduled for completion early this summer.

The Roblin District Hospital, Roblin, Man., has been awarded a federal grant of $15,500 toward the cost of extending its accommodation. This is the second grant to the Roblin Hospital — $19,000 having been allotted in 1949. The current grant, which is matched by the provincial government, goes toward construction which will allow space for 13 additional patients' beds and five beds for nurses.

A federal grant of $381,500 has been allocated to help meet the building costs of the new St. Thomas-Elgin General Hospital, St. Thomas, Ont. This hospital, scheduled for completion shortly, will have medical, surgical, and obstetrical facilities to serve about 50,000 people in St. Thomas, Aylmer, Port Stanley, West Lorne, and surrounding districts. When the new building is ready for use, the present Memorial Hospital will be converted to the care of long-term patients and the present temporary accommodation for these patients at New Sarum will be abandoned. Costs of the new hospital are being met by public subscription and by grants from the federal and provincial governments, the County of Elgin, and the City of St. Thomas.

Hospitals in London, Galt, and Hamilton, Ont., have just been awarded federal grants totalling $209,000 to help meet the costs of adding additional accommodation for patients. More than $8,000 has been earmarked for the Woodeden Hospital, near London, for the construction of two 10-bed cottages. This hospital, operated by the Ontario Society for Crippled Children, operates a year-round program for the care and treatment of spastic paralytic children from all parts of Ontario. It now has a bed capacity of 80.

The Hamilton General Hospital, Hamilton, Ont., will receive $10,000 toward the cost of providing space for 10 additional beds in a new admitting and emergency department. Construction is scheduled for completion next spring. This is the third federal grant to this hospital, others totalling $662,000 having been made in 1949 and 1951. A grant of more than $191,600 has been set aside for the new South Waterloo Memorial Hospital, now under construction in Galt. It will have 170 beds, a 44-bassinet nursery, and modern medical, surgical, and obstetrical services. The building is scheduled for completion this year and will serve approximately 32,000 people in Galt, Preston, Hespeler, and surrounding townships.

In Meaford, Ont., a private home is being converted for use as a residence for 13 nurses. A federal grant of $6,500 has been approved to help with the cost of renovations. At the Ongwanada Sanatorium, Kingston, Ont., a wing which has never been used for patients is being converted into a 10-bed nurses' residence. A grant of $5,000 has been approved toward the cost of alterations.

Hospitals in Toronto, Sudbury, Peterborough, Hamilton, and Mount Forest, Ontario, have just been awarded federal grants toward the cost of building nurses' residences. The largest grant, $118,500, goes to the Toronto General Hospital to help meet the costs of a 237-bed addition to its nurses' residence. The St. Elizabeth School of Nursing, operated by St. Joseph's Hospital, Sudbury, has been awarded more than $18,200 toward the cost of providing living accommodation for an additional 93 nurses.

A grant of $11,000 has been earmarked for the nurses' residence of St. Joseph's Hospital, Peterborough. This construction will provide accommodation for an additional 22 nurses. St. Joseph's Hospital, Hamilton, will receive $9,500 toward the cost of converting a former private residence into a nurses' home, and $7,000 has been allocated to help toward the cost of construction of the recently-opened nurses' residence for the Louise Marshall Hospital, Mount Forest.

Professional Training

The federal government has agreed to underwrite part of the costs of a short course in hospital accounting to be given in Nova Scotia. The course is designed generally to improve accounting practices in hospitals and also to obtain more uniform accounting systems. The training will be made available to 35 accountants — one from each hospital in the province. The federal grant toward the costs of the training will be $1,750.

A bursary has been awarded to a member of the Prince Edward Island division of tuberculosis control for a refresher course at the Toronto Hospital for Tuberculosis, Weston, Ont. Another bursary for a year's training as a medical record librarian has been awarded to a member of the staff of the Children's Hospital, Winnipeg, Man., who will take her course at St. Michael's Hospital, Toronto.

A new training course for aides in occupational therapy, being given at the Ontario Hospital, Kingston, is being supported by a federal health grant. For some time there has been a shortage of trained occupational therapists particularly for work in mental hospitals. With the co-operation of the Canadian Association of Occupational Therapy and the Canadian Physiotherapy Association, plans have been worked out to train aides who will assist the graduate therapists in devel-

(Continued on page 16)

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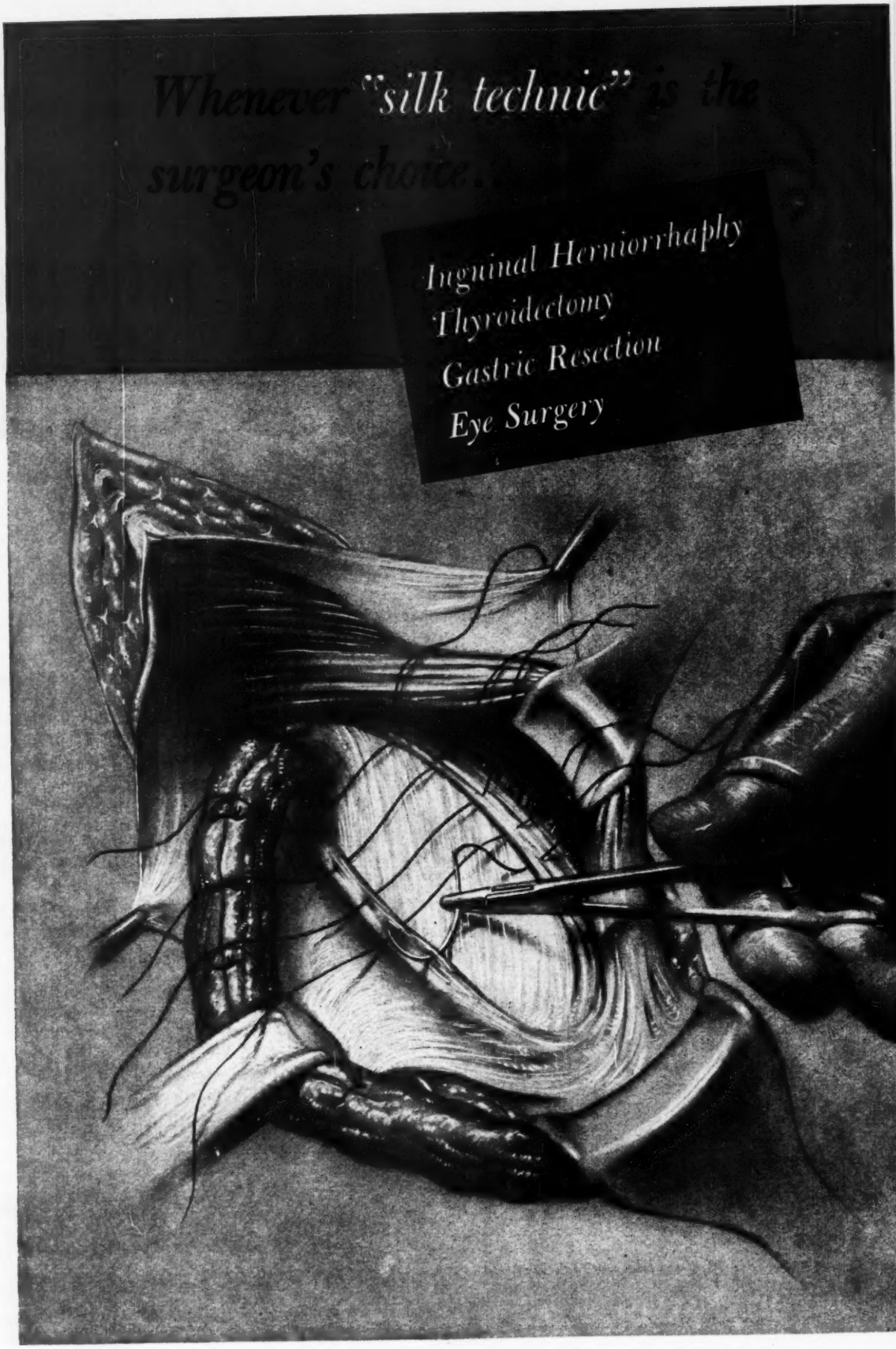
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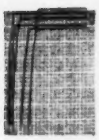

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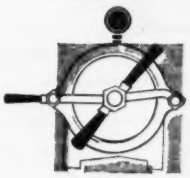

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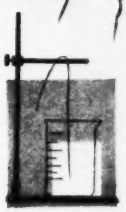

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Federal Grants

(Continued from page 12)

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The course requires three months to complete and not more than 20 students can be accepted at any one time. It is planned to give the course three times a year. Each training period provides for lectures on the application of occupational therapy to psychiatric and other problems, as well as extensive practical training. The federal grant of $19,000 in the current fiscal year provides for the purchase of equipment and supplies needed to get the course under way and assistance towards the maintenance cost of the students.

Federal funds have been set aside for an annual bursary to train laboratory technicians at Regina College, Regina, Sask. In this way public health officials hope to be able to obtain a continuing supply of trained technicians to work in the provincial laboratories.

Public Health

The Montreal Neurological Institute has just been awarded a federal grant of $75,000 for the purchase of special, technical equipment. This brings to $468,483 the amount so far allotted by the federal government to buy equipment for the Institute's expanded treatment facilities.

About 14 per cent of admissions to the Institute are persons with brain tumors which require expert surgical and medical care. About 29 per cent have mental disorders or illnesses in which mental disorders are prominent features, and about 15 per cent of admissions involve patients with epilepsy. Special equipment for the anaesthesia department has been obtained with federal funds for the continuous recording of arterial pressure during operations on epileptics and a substantial amount has been allotted to equip a new isotope laboratory which will utilize products of the atomic age in furthering medical research. The remainder of the grant is being used for highly complex and expensive equipment for the divisions of anatomy and pathology, neuroradiology, neurophysiology, electroencephalography, neurochemistry, and surgery. Much of the equipment is specially constructed for the Institute.

A grant is being provided to cover the salary of a chemical analyst who will join the staff of the provincial health laboratory in Saskatchewan. He will concentrate on the analysis of water samples from the 45 municipal waterworks systems in Saskatchewan and will also do certain chemical analyses for municipal sewage systems. The information obtained is expected to be valuable to the provincial division of sanitation in determining the efficiency of the various water and sewage treatment and disposal systems in the province. The work will take about a year to complete.

The federal government has also agreed to meet the costs of three portable respirators purchased for emergency use during the past summer's polio epidemic. They are being used at the City Hospital, St. Paul's Hospital, and at the air ambulance base, Saskatoon. Cost of this equipment is estimated at $5,400.

Tuberculosis

Programs for training more nurses

(Concluded on page 20)

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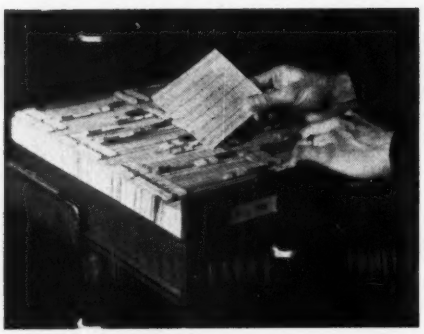

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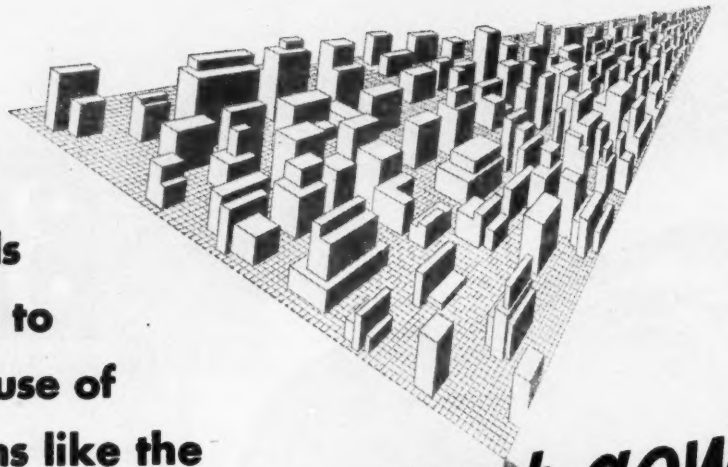

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Federal Grants

(Concluded from page 16)

in tuberculosis control and for the training and employment of additional laboratory personnel in Saskatchewan were among projects recently approved for federal health grants. Since June 1945, an arrangement has been in effect for the training of a small number of student nurses from general hospitals in the prevalence, treatment, and prevention of tuberculosis. This instruction was given at the Fort Qu'Appelle Sanatorium. Under the new plan, the program is to be revised and extended to include training in the sanatoria at Prince Albert and Saskatoon. Eight training courses, each six weeks in length, are to be given every year. Fort Qu'Appelle will take 20 student nurses for each course from the general hospitals in Regina and Moose Jaw. The Saskatoon sanatorium will take at least 10 nurses per course from the Saskatoon general hospitals, and the Prince Albert sanatorium will train 15 per course from the nurses' training schools in Prince Albert, Yorkton, and Humboldt.

The federal grant of about $4,000 for the current fiscal year helps provide three full-time instructresses to organize the courses, as well as meeting other costs. The courses are being arranged in co-operation with the Saskatchewan Anti-Tuberculosis League, the Saskatchewan Registered Nurses' Association, and the University of Saskatchewan. They are expected to be valuable not only in giving student nurses a better all-round training but also in interesting some of them in specializing in the nursing of tuberculosis patients.

New Approach to X-raying Bronchial System

An investigation into new methods of x-raying the bronchial system is being undertaken by the department of radiology of the University of Western Ontario, London, with the support of a federal health grant. The study is being directed by Dr. Dirk L. Bartelink, professor and head of the faculty of medicine's department of radiology and head of the diagnostic x-ray department of Victoria Hospital, London.

The current method of x-raying the bronchial system is an unpleasant one for the patient and involves anaethetizing the upper airways of the bronchial tree and the direct injection of an oil which, by contrast, will show up on an x-ray film. The new approach is to find whether or not it is possible for a patient to inhale the contrast oil or dust in sufficient quantities to penetrate even to the smaller bronchi without upsetting the normal functioning of the bronchial system. The initial studies will utilize a model of the bronchial system and it is expected that extensive experimentation will be required to ensure perfect safety before any new method is used in actual practice. It is expected that it will take about a year to complete the investigation. A grant of $700 has been earmarked to cover the cost of equipment and supplies needed for the experiments.

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And gluttons old in sin
Mistake themselves for carpet bags
And shovel victuals in.

—*Sir Walter Raleigh.*

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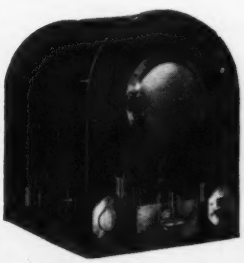

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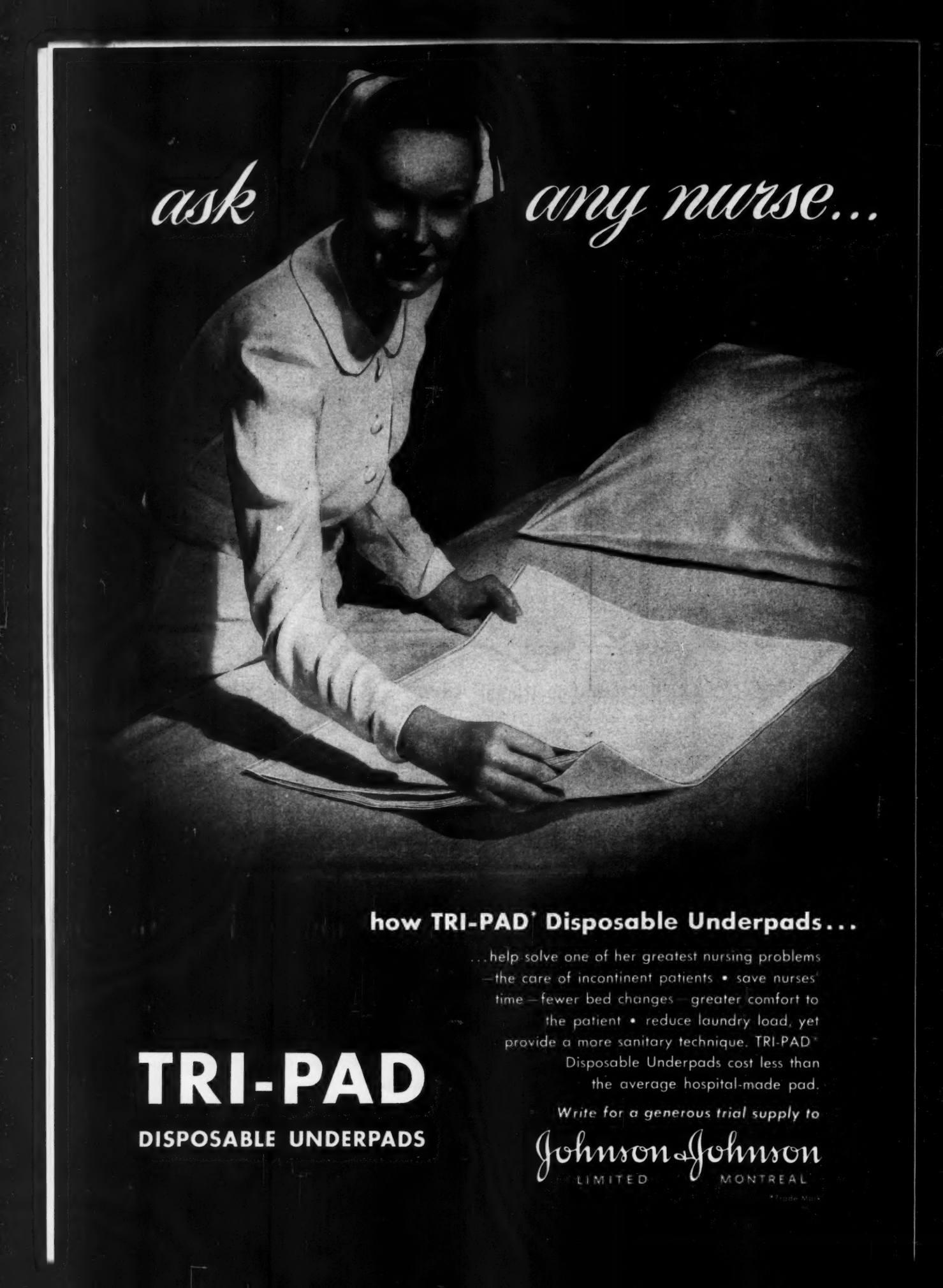

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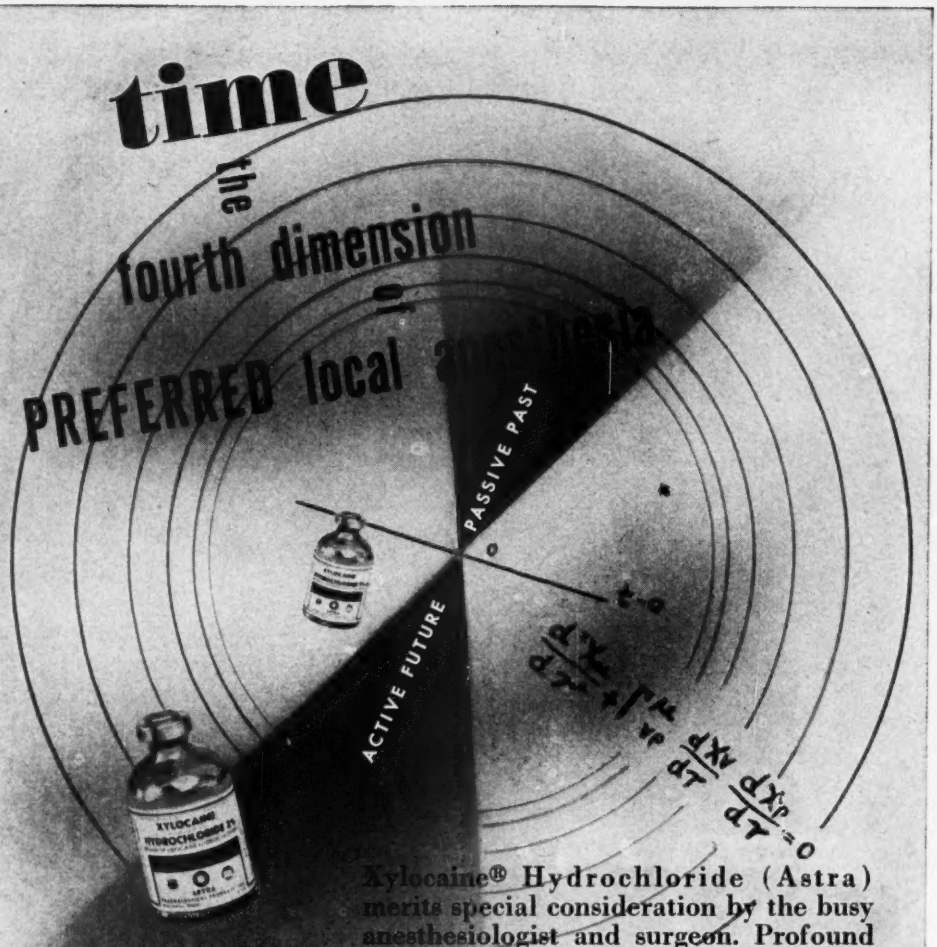

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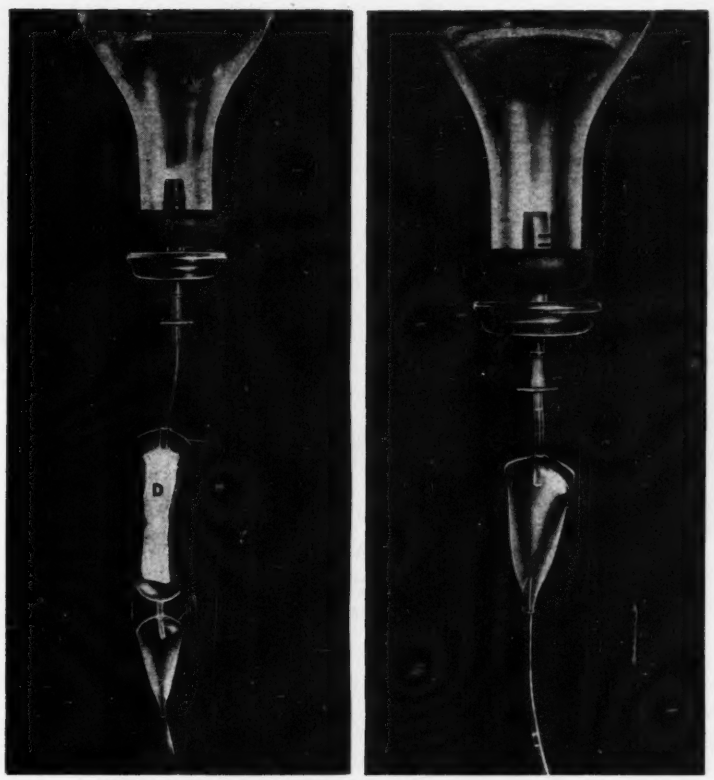

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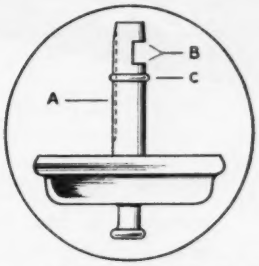

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*Sack, Theodore et al, The Preservation of Whole ACD Blood Collected, Stored, and Transfused in Plastic Equipment, Surg. Gyn. Obst. : 95, 113-119, 1952.
Walter, Carl, W., A New Technic for Collecting, Storage and Administration of Unadulterated Whole Blood. Surgical Forum.
Walter, Carl W., and Murphy, Wm. P. Jr., A Closed Gravity Technic for the preservation of Whole Blood in ACD Solution utilizing Plastic Equipment. Surg. Gyn. Obst.: 94, 687, 1952.

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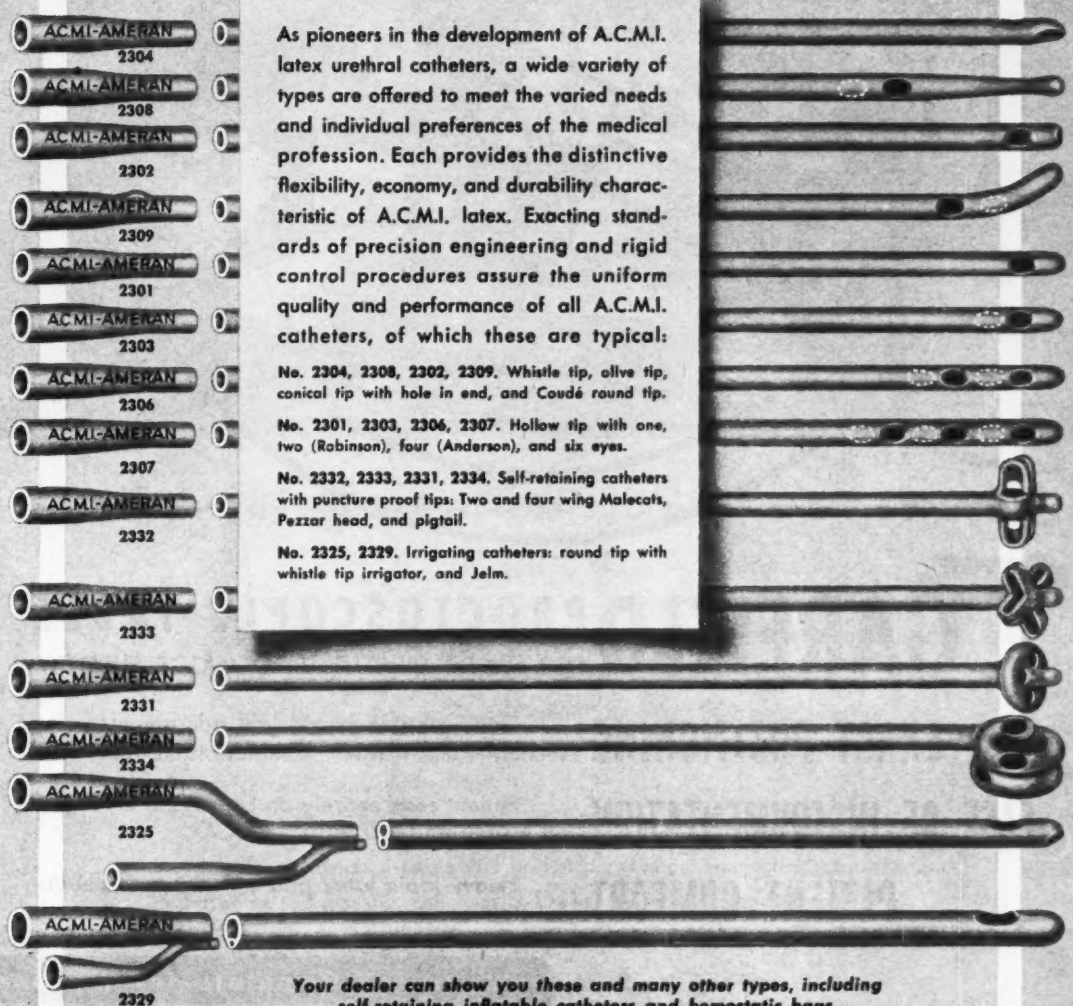

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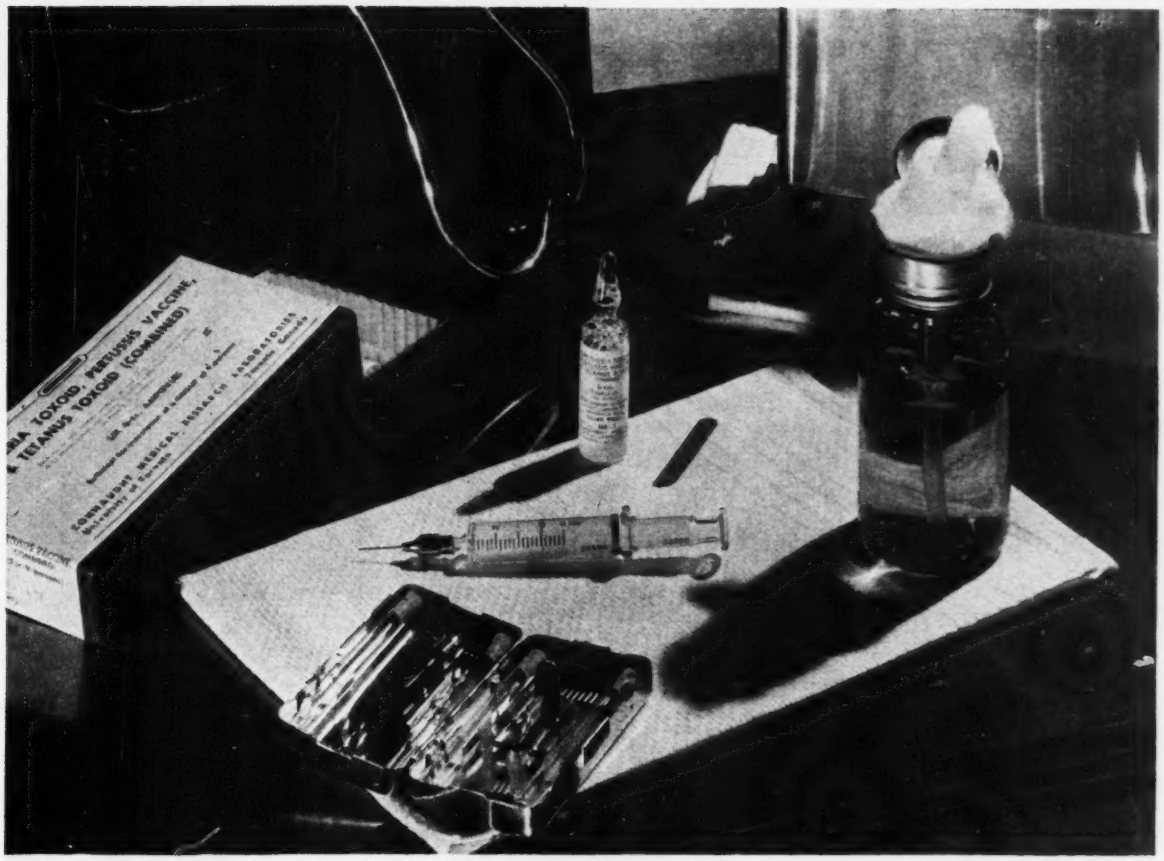

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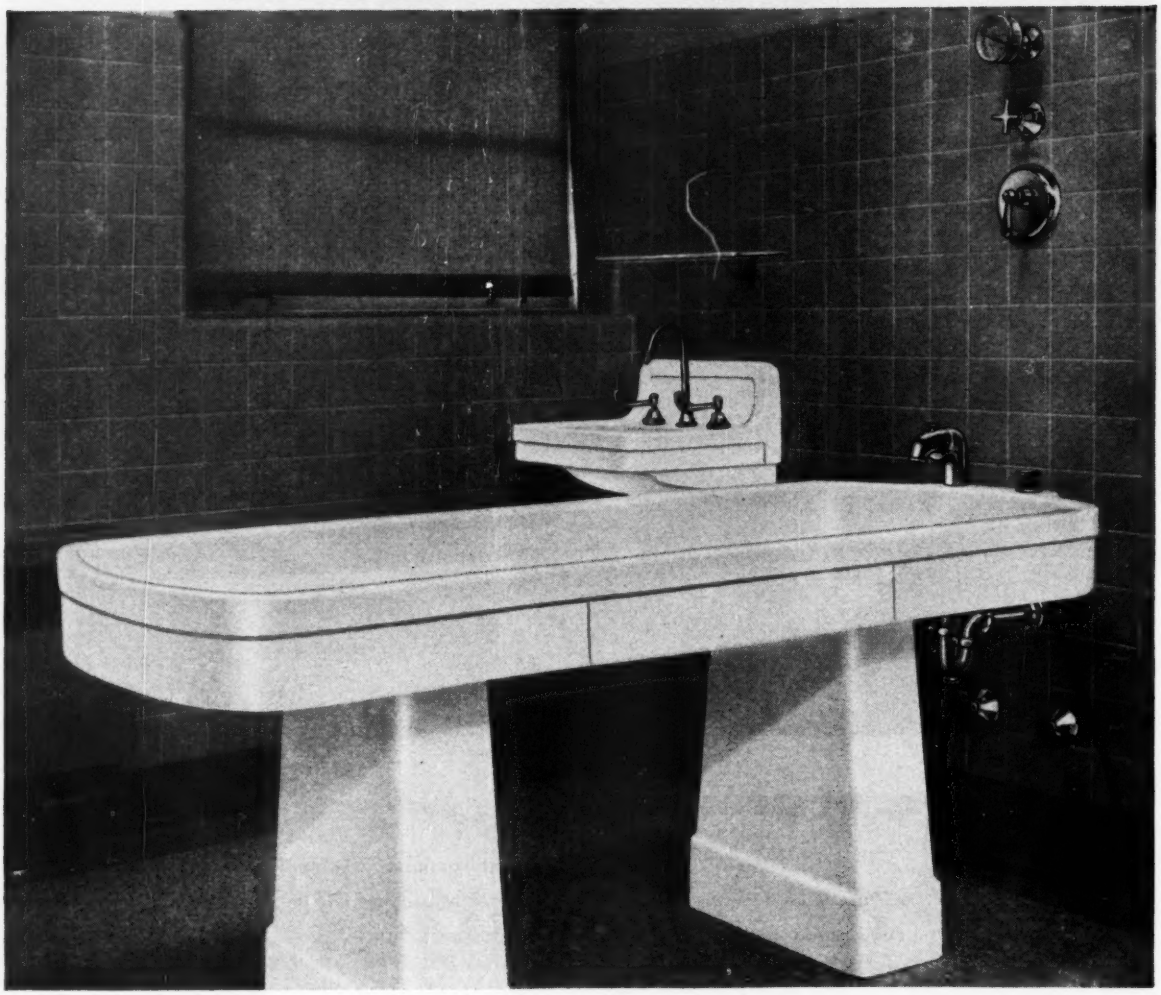

ABOVE: Crane Duraclay Emergency Bath.
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A. L. Swanson, M.D., Editor

The CANADIAN HOSPITAL

Toronto, February, 1953 Vol. 30 No. 2

Obiter Dicta

Lighting the Lamps of Learning

IN 1913, when the American College of Surgeons was first established, one of the basic requirements for fellowship was the presentation of one hundred complete hospital records of patients operated on by the surgeon applying for fellowship. From the outset it was clear that many surgeons could not meet this specification, due to the lack of hospital facilities and, in particular, the lack of adequate systems of medical record keeping.

As a result, the College established its hospital standardization program in 1918 for the purpose of improving hospital care. The medical record department received special emphasis because of the part it necessarily plays in medical research, medical training, and as a guide to the quality of medical practice in the hospital.

The intervening years have proved the value of the standardization program in assisting hospitals to become better (and safer) organizations for healing. Likewise, as hospital departments expanded and improved, the medical record departments grew in stature to become as much a part of a progressive institution as radiology or admitting. With this new prominence of the department, educational facilities for specialists (medical record librarians) were developed. In Canada six schools have been established in hospital centres*, each giving a one-year course of formal training and graduating a small number of students annually. However, these schools have not proved sufficiently large or numerous to provide the necessary number of trained personnel. As a result, many hospitals have been unable to secure qualified librarians and additional training facilities appear necessary.

For some time the Canadian Hospital Council and the Canadian Association of Medical Record Librarians have been considering possible solutions. Could more schools, with greater enrolment, be established? However, it takes time to locate qualified instructors and to find departments with sufficient facilities, time, and money, to carry out a successful program. Assuming that more schools could be opened, would medical record personnel have the necessary funds and free time to attend for one year? Finally, what would become of the experienced but academically unqualified aspirant for medical records training? Educational standards must be maintained for the professional standing of the R.R.L. certificate, but many competent people in medical record departments require and desire further training to improve their ability to serve and to increase their status.

In an effort to meet the problem in a practical way, the two organizations, with the support of the W. K. Kellogg Foundation, have arranged an extension course in medical records, to commence in the fall of 1953 (see pages 41 and 42). Organized on lines similar to the extension course in hospital organization and management, which has proved so successful; with the experience of D. M. MacIntyre, assistant secretary of the Canadian Hospital Council; and with the preparation of the lessons under the direction of Doris McPherson, R.N., R.R.L.; the course promises to light another lamp of learning in the Canadian hospital field.

It is hoped that many hospital boards and executive officers will encourage and assist their records personnel in undertaking this course. Possibly at least part of the expense could be defrayed through voluntary or governmental bursaries.

* *Schools are located in the following hospitals: Halifax Infirmary, Halifax; Hôtel-Dieu de Montréal, Montréal; Hotel-Dieu, Kingston, Ont.; St. Joseph's Hospital, Peterborough, Ont.; St. Michael's Hospital, Toronto; and St. Boniface Hospital, St. Boniface, Man.*

File 1952 Returns This Month

IN RECENT years, hospital statistics issued by the Dominion Bureau of Statistics have been published so long after the period being reported as to render them almost valueless. This criticism is frequently heard at hospital meetings. Everyone concerned, the Bureau, government officials, and hospital administrators, want the situation corrected.

Why can hospital statistics not be published at least in the year immediately following the period to which they apply? In the past, there have been a variety of reasons, or excuses, offered to explain the delay. The hospitals are tardy in filing their returns; a provincial department of health delays forwarding the information destined for the Bureau of Statistics; or the Bureau itself is behind schedule.

Now is the time to do something about all this. Much effort has been expended in compiling the Canadian Hospital Accounting Manual and in streamlining the statistical reporting schedules. But these developments will not in themselves produce current statistics. They are but tools to assist in doing a better job.

To obtain current provincial hospital statistics demands that each and every hospital complete and file reporting schedules as soon as possible. To obtain current national hospital statistics, demands that each provincial department in turn be geared for speedy checking and processing of the returns and for their early transmission to the bureau of Statistics.

We are assured by the Dominion Statistician that, if these steps are taken by all concerned, prompt tabulation and publication of 1952 national hospital statistics will result.—*M.W.R.*

Il faudra faire parvenir le relevé de 1952 dès février

DEPUIS quelques années, les statistiques se rapportant aux hôpitaux ont été publiées par le Bureau de la Statistique si longtemps après la période à laquelle elles se rapportent, au point de les rendre presque sans valeur. On en passe souvent la remarque aux réunions des personnels d'hôpitaux. Tous — le Bureau, les officiers du gouvernement et les administrateurs d'hôpitaux — veulent améliorer cette situation.

Pourquoi ces statistiques ne pourraient-elles être publiées au moins aucours de l'année qui suit immédiatement la période à laquelle elles s'appliquent? Par le passé, on a donné une foule de raisons — ou d'excuses — pour expliquer ce retard: les hôpitaux sont lents à faire parvenir leurs rapports; un département provincial de santé retarde en les faisant parvenir au Bureau, ou le Bureau de la Statistique lui-même est en retard.

Il faut dès maintenant remédier à cette situation. On a mis un grand effort à préparer le *Manuel de Comptabilité des Hôpitaux du Canada*, et à moderniser les formules pour les rapports statisticaux. Mais ces développements en eux-mêmes ne produisent pas des statistiques courantes. Ils ne sont que des outils pour faciliter un meilleur travail.

Pour obtenir des statistiques provinciales courantes sur les hôpitaux, il faudra que chaque hôpital complète et fasse parvenir son rapport aussitôt que possible. Afin d'obtenir des statistiques courantes nationales, chaque département provincial à son tour doit être organisé afin de pouvoir les vérifier et les classifier rapidement, et les faire parvenir de bonne heure au Bureau de la Statistique.

Le Statisticien du Dominion nous assure que, si ces précautions sont prises par tous les partis interessés, il en résultera une tabulation et publication rapide des statistiques sur les hôpitaux pour l'année 1952.

Look About You!

IS HOSPITALIZATION adequate in your town — in your region — in your province? Are patients admitted promptly, without waiting days or weeks for accommodation? When they are admitted, do you offer every facility consistent with the size and departmentalization of your hospital? Are you operating efficiently and safely in fire-resistant buildings, with modern operating rooms, good laundries, clean, bright kitchens and many other necessities for modern-day hospital care? If your answers to these questions are all in the affirmative, read no further.

There are certainly few areas in Canada where hospitalization may be considered truly adequate even under normal operating conditions. Civil disaster or military action would pose almost insurmountable problems in most locations. Despite a far-sighted health grants program that has seen over 40,000 new hospital beds in Canada in less than five years, much remains to be done.

The hospital construction grants amounting to over $13,000,000 per year have never been fully utilized. Is this because new hospitals and modernized facilities are not required? Or is it that $1,000 per bed, helpful as it is, has relatively shrunken in value with the increase in hospital building costs, leaving the balance of hospital construction cost a terrific community burden? A few years ago, eight to nine thousand dollars per bed was a reasonable building figure and a $1,000 per bed grant amounted to approximately 12 per cent. Today, with building figures hovering near the $16,000 figure, the same grant is equal to only 6 per cent of the cost.

In the "Speech from the Throne", November 20th, 1952, reference was made to the "extension with certain changes" of the national health grants program. Rumours have been rife that "certain changes" may represent a substantial decrease in available money for hospital construction. While, in the light of the unused construction money and the 40,000 new beds already provided, this might seem reasonable, should we not look about us and consider the matter closely?

In 1951, the government broadened the scope of the construction grants to include nurses' homes and outpatient facilities. Should not a further expansion of coverage be considered now? Perhaps the total yearly grant need be no larger or could even be reduced; but hospitals do need laundries, boiler plants, office space, and a host of other facilities not presently covered. Would an

increase in the coverage, sufficient to return the percentage of the government's contribution to its former rate, be the answer? In the face of doubled building costs it would seem that the grants of five years ago are no longer adequate. Perhaps the total number of new beds may be decreased but, for the beds that are to be built, more assistance is needed.

Have you informed your association of your views so that the executive may approach the provincial minister of health concerning hospital requirements and also brief the Canadian Hospital Council for action on the national level? The government must have the facts if it is to act wisely. It can best be informed by your associations acting on behalf of all members.

Teachers View Medical Internship

Education or Service

G. E. Hall, M.D., Ph.D., F.R.C.S.,
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THE RELATIONSHIP between hospitals and universities is obviously a big subject and covers a very broad field. To deal adequately with such a significant relationship would require the convening of several seminars. Rather than deal superficially with many or all aspects of the subject which would belie its importance, it is preferable to limit it to the field where our relationship is most intimate—the field of medical education.

For many years, the teaching hospitals and the universities have co-operated in the field of medical education. This has been to some extent a marriage of convenience but it has been proved to be a development, like marriage, of benefit to both parties. It has allowed the universities to develop teaching methods which insure a graduate of high quality and skill. It has provided facilities for clinical research resulting in developments of importance to the well-being of all. The hospitals, too, have benefitted equally with the universities in this joint effort. Hospitals as we now know them would not be possible with graduates less adequately trained. Those hospitals which have been fortunate enough to be directly associated with a university have shared with the unisity the advantages to be derived from the high quality of trained staff which can be established in such a setting. It is not by mere chance association that most of the famous hospitals throughout the world are those which became an integral part of a university teaching program. This relationship is not one determined only by geographic proximity but it is also a state of mind, since the university association carries with it definite responsibilities as well as definite advantages. This partnership reaches its highest state of development only with the full appreciation that the problems which a university affiliation imposes are many times compensated for by the inherent advantages of such an arrangement.

To understand fully the relationship between these two social organizations, we must understand the long-term development of this relationship. What was the origin of mutual dependence? What were the long-term forces which have tended to bring our futures so closely together? It is only by understanding and appreciating these things that we, the hospitals and the universities, can acquire a broad perspective upon which to plan and develop for the future; the minor petty irritations of day-to-day contact are simply incidental.

Medical education on this continent has passed through three distinct phases which have altered the relationship between the hospitals and the universities.

Medical education had its origin in the apprenticeship system. Under this system, a young man who was interested in becoming a physician would arrange, personally, with a practitioner to spend an undetermined number of years under his direction. During this period, he would carry out many tasks. In return for his services, he would receive whatever instruction his tutor would feel free to provide. We need not be too critical of this type of arrangement since this stage of development was strictly consistent with the then pioneer nature of the United States and Canada and with the dearth of hospitals at the time. The early development differed somewhat in the British Isles where, because of the earlier growth of cities and of hos-

An address delivered by Dr. Hall at the Ontario Hospital Association convention, Toronto, Oct., 1952.

pitals, a number of medical schools were organized as integral parts of the hospitals, under somewhat the same arrangements as exist in many hospitals for the training of student nurses. It was still, however, on the apprenticeship basis although the unit of function was the hospital rather than the individual.

Proprietary "Schools"

The nineteenth century saw the apprenticeship system of medical training giving way to the rapid growth of so-called proprietary schools of medicine. It is only for sake of simplicity that the term "school" is used here for they, with few exceptions, were far from reaching the minimum requirements for such a designation. The usual development was for a number of physicians to group together and establish a "school" with little concern for need or facilities and even less concern for education. The quest for profit was the usual motivation. Little was required other than a lecturer and protection from the weather. By keeping facilities and operating costs at a minimum it was hoped to obtain a profit from the student fees. Since the cheapest method of instruction is that of the lecture, the training was entirely didactic and repetitive. There was no thought of providing either laboratory or clinical experience; it was most unusual for such a "school" to have even the remotest association with a university. This system resulted not only in large numbers of "schools" but also of comparably large numbers of graduates of poor quality. The situation at that time was aptly described by Abraham Flexner, who was more responsible than any other single person for the present method of medical education and training. He said: "Medical colleges have multiplied without restraint, now by fission, now by mere spontaneous generation. The United States and Canada have in a little more than a century (19th) produced 457 medical schools, many of course, short-lived and perhaps 50 still-born. These enterprises — for the most part they can be called schools or institutions only by courtesy — were frequently set up without regard for opportunity or need."

Re-organization

In 1910, the subject of medical education was thoroughly reviewed and a system of control and regulation was instituted which laid the foundation for the present method of medical instruction and brought the medical schools (as they existed at that time), the universities, and the hospitals into close relationships. This development was primarily the work of the Council on Medical Education of the American Medical Association which had been established in 1904. Because of the conditions which were disclosed by the council and in order to obtain the appraisal of an unbiased and qualified agency, the Carnegie Foundation for the Advancement of Teaching was requested to undertake a study of the situation. The Foundation responded to the appeal and commissioned Abraham Flexner to make a comprehensive study of all medical "schools" in the United States and Canada. This report was responsible for the complete reorganization of medical education and established the pattern of instruction as we know it today. It clearly set forth the many inadequacies in the existing "schools" and the need for improvement. The emphasis was directed from the didactic to the clinical method of teaching. It required of all "schools" that they affiliate with a hospital in order to provide clinical instruction. As a result of this and other recommendations, many of the "schools"

"Village Street", by Dr. G. H. H. Booth, Agassiz, B.C.

were forced to close their doors. Those which survived did so by becoming closely integrated with a university. Many developed working arrangements for affiliations with hospitals in the vicinity while others developed hospitals of their own.

Patients for Teaching Purposes

This development meant that all medical schools (now with the quote marks removed) must have patients who could be used for teaching purposes. It must be emphasized here that this meant not just patients but patients available for teaching. To meet these requirements patients must come directly under the supervision and care of the professor in the university department concerned. No other arrangement allows the universities to meet their obligations to the undergraduate student. It is of little use to a medical school to be affiliated with a hospital having 1,000 beds if these beds are not readily available to the teaching staff and to the students. The public ward or staff bed arrangement has met adequately the teaching needs of the universities over the years and in return these patients have received the highest quality of medical care available. It has allowed the staff to be concerned primarily with teaching and the advancement of medical science and, in this, the patient and the hospital benefit. The hospitals have benefitted not only in the stimulus that a teaching contact brings but also in being able to provide the highest quality of medical care, at essentially no cost to the hospital, to a group of patients ordinarily unable to provide this care on their own.

Although the ward or staff bed arrangement has served well over the years, there have appeared recently signs of strain in this system. This situation may simply be a transient thing, or it may be significant of the influence of a broad social change which may gradually force the university to consider some other type of arrangement. These difficulties appear to be related, partially, to the high economic level now enjoyed by so many people and which results in a greater proportion of the population seeking private and semi-private hospital accommodation and, partially, to the tremendous growth of health insurance of the hospital or comprehensive type. While this latter development is serving a very useful purpose, nevertheless, it is tending to limit the number of patients who are available for teaching purposes. There is little evidence that this critical by-product of health insurance is being given the serious thought which it deserves. The medical schools are closest to the problem and are most aware of this threat to the quality and even to the quantity of their product. However, it is a problem of equal concern to the hospitals and the people at large for, after all, they are both the consumers of the product which we in the universities produce. I do not know what the solution will or can be. What I do know is that some compromise must be made if health insurance and other forms of hospitalization insurance continue to cover a constantly increasing proportion of our population. If medical education is to continue at the present level of efficiency there must be available teaching beds which are under the control of the university department concerned. It would be of little avail, in fact it could be disastrous, if we, through our search for economic security in the field of health, should set in motion forces which would drastically interfere with the quality of that very service which our people are seeking.

Graduate Education

With the increasing complexity of medicine, few would consider that a student is equipped for the practice of medicine when he has completed an undergraduate course and received his degree of Doctor of Medicine. One or more years of training in hospital is required. Many of the states in the United States, and a number of provinces in Canada, now require that an internship be served before a licence to practice is granted. Although this aspect of training has been more directly the responsibility of the hospitals, it is of concern to the university as it represents a very specific phase in the training of a physician and surgeon. Graduate medical education can readily be considered in two phases: firstly, the rotating general internship; and, secondly, residency training. Less easily, because of the lack of experience and of the lack of organized facilities, can we consider the important phase of graduate training for the specialty of general practice.

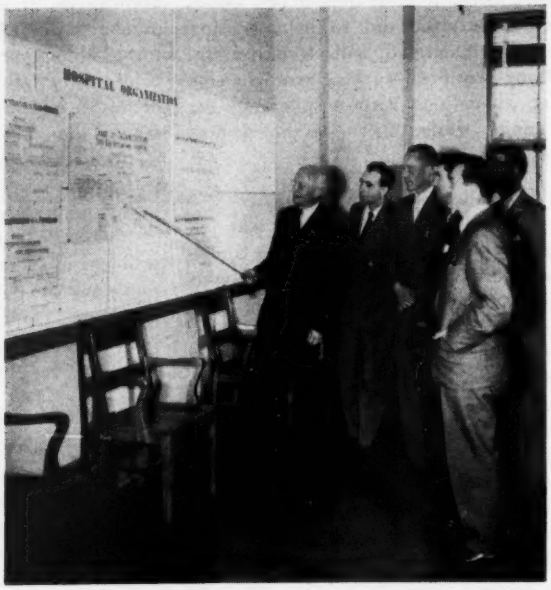
The use of interns in hospitals was originally due to the influence of the European-trained staff physicians and the readily recognized need for a resident staff by the authorities of the early hospitals. Since the hospitals were unable to attract the few practitioners available, the new graduates appeared to provide the means of meeting this service need. Early development, during the nineteenth century, coincided with the period when medical schools were sprouting like mushrooms and when quantity rather than quality of graduates was the outstanding characteristic. The number of hospitals was limited and the internships were few in number falling far short of the number of medical graduates. Appointments were made through competitive examinations and successful candidates formed a small elite group. Because of this, it was inevitable that the interns would, in time, gradually fill the vast majority of the visiting staff appointments. This achievement carried with it the prestige of a commanding position and the recognition as a specialist in the chosen field.

The American Medical Association, which had so profoundly influenced undergraduate medical education, had a similar effect on the development of internships in the hospitals. The first educational number of the *Journal of the American Medical Association* appeared in 1901. The issue of 1904 contained an editorial on the "Education of the Intern", and described in seething terms the haphazard intern system of many hospitals of the day. The internship facilities available at that time would provide for less than 50 per cent of the graduating classes. There followed a marked but gradual increase in the number of available internships, an increase which was due both to the great development of new hospitals and to the establishment of internships in a greater proportion of all hospitals. In 1914, the number of house-staff listed in the *Journal of the American Medical Association* was 503. By 1936, this had risen to 1,760, an increase of 250 per cent.

You will recall that this change coincided with the period during which the "schools" were being re-organized with a resulting increase in the quality but with a decrease in the quantity, both of schools and medical graduates. It was inevitable, therefore, that since there were two diametrically opposite developments, one which limited the number of graduates and the other

(Continued on page 92)

Eyes and Ears in Education



Professor Harvey Agnew explains certain aspects of hospital administration by means of charts.

Eugenie M. Stuart, M.H.A.,
Assistant Professor of Hospital Administration, University of Toronto, Toronto, Ont.

PROVERBS such as "one picture is worth a thousand words" have been known to educationists for many years. Recently, surveys based on experiments in adult as well as child education report that "through the visual aids students learn up to 35 per cent more in a given period of time and remember 55 per cent longer"*. Various types of visual aids have been used in education since prehistoric times. Cave men carved crude figures in sand and rock to create lasting and effective images in the minds of their proteges — Aristotle and the Alexandrians developed anatomical charts decades before the actual teaching of anatomy. Throughout the years, well illustrated text books have been published and used in our schools; and the blackboard[1] is one of the essentials in fixed physical equipment in every classroom. All these and more are visual aids. Today we think of slides, films, filmstrips, and even television, as the most recent developments in audio-visual aids in modern education. As one great educator has aptly stated: "To see, to hear, to understand, this is the essential triad that leads to ultimate wisdom".[1]

The development of the above media in the modern world has lead to changes in and additions to traditional methods of teaching. During the past five years the use of these new "tools" has spread rapidly in elementary and secondary education but in many of the higher seats of learning the transition is slow.

In the Department of Hospital Administration at the School of Hygiene, University of Toronto, much thought has been given to the development of special techniques which would supplement the time-honoured lecture, project, and discussion method of teaching. Few fields of graduate study require such a broad background of business and professional knowledge as does hospital administration. While there are no prerequisite subjects for admission to the course, students who hold degrees in commerce must give extra time to medical science subjects and those who hold degrees in medicine must spend extra time on business management subjects. One academic year (followed by residency in a hospital) is a comparatively short time in which to cover such a very heavy program. For this reason it has been necessary to devise ways and means of presenting to students the maximum amount of study material in each study period.

Planning for the use of audio-visual aids in teaching the numerous subjects has been a trial and error effort. Assembling the illustrative material has required time and persistence; but the hours spent in selecting, previewing, evaluating, and finally using these materials has been more than repaid by the results achieved through improved utilization of the available teaching hours. There is saving in both teacher and student hours and these may be calculated as a saving in money when hours are estimated in monetary symbols. The faculty of this department is now convinced of the merits of audio-visual aids in education for hospital administration.

Display Room

A year ago, as a result of the increasing use of audio-visual aids in our program, a special room was provided for display of the illustrative materials which are in constant use by students in hospital administration. One wall of this room has an acousti-cellotex covering with special direct lighting. This wall is used for display of charts, maps, graphs, photographs, posters, et cetera. The exhibits are planned around the central theme of the subject being currently studied. Planning and collecting the display material for any unit of the curriculum may be as-

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* *Strauss, L. H. and Kidd, J. R.; "Look, Listen and Learn", page 11, Physicians' Record Co., Chicago.*

[1] *Waters, Prof. Louis, Southwestern Medical College, Dallas, Texas, in a lecture in 1945.*

signed to a student as an educational project. In a glass display case mounted on another wall may be seen materials illustrating medical science subjects. They are thus available and accessible to students at all times. The room contains also a peg board, by means of which flow of work as well as motion and time studies may be demonstrated and discussed. That the visual aids may be of maximum benefit, the students must be prepared to interpret the symbolic aid and the arrangement of the exhibits must fit into the general sequence of classroom presentations. Lectures are often delivered in this room when illustrative materials are to be used.

Models

Through the courtesy of the Toronto Western Hospital, Toronto, Ont., the facilities of the new well-equipped science laboratory in the nursing education building there have been made available to our students in hospital administration. The laboratory method "emphasizes education as an active, direct experimental activity".* Here the students see and handle exact scale models. The skeleton as a whole, as well as the individual bones are studied; the cut-away model or manikin shows the relative size and relationships of the structures of the human body. Scaled-up models of special organs demonstrate functions which the human eye cannot appreciate; as do also mock-up models (*e.g.*, one of the latter, made from a bell jar and balloons, demonstrates the respiratory function). By means of these models, important physiological activities and anatomical features may be readily explained.

Through the courtesy of the School of Architecture, University of Toronto, terrain models and plans of various sized hospitals, as well as health and welfare units, have been made available. These form the basis for discussion in the curriculum unit on hospital planning and construction. Study of the plans and models directs attention to site, land elevation, public utilities, orientation of buildings, and flow of work within the hospital as well as in the individual department.

Field Trips

Field trips provide a wealth of visual aids and approximately 120 of the scheduled class hours in the study of hospital administration are spent in trips to local hospitals, health units, community service organizations, surgical supply houses, and related departments of the university, *e.g.*, the faculty of applied science and engineering. A planned classroom introduction to the field trip, using other audio-visual teaching aids such as film strips, films, slides, and posters, conserves time and vitalizes the field experience. This introduction or preparation for the experience is probably even more important than what is actually presented in the field trip situation. The conference follow-up, held after the field trip, will determine whether its purpose has been achieved. The value of the trip is thus dependent upon preparation, actual observation, and follow-through. When these three stages are planned and carried through successfully, field trips prove to be among our most valuable experiences in this academic year.

Opaque slides were among the first and most readily available materials for projection in classrooms and hence this type of visual aid is used to considerable extent. Illustrations from text books, journals, newspapers, and advertising sources, have been assembled for projection in the many units of study in this course. The outstanding merit of the opaque projections is the wide variety of materials which may be shown in colour as well as in black and white.

Professor Harvey Agnew centres his lectures around his collection of black and white slides which he has carefully developed to illustrate phases of hospital planning and construction, organization and management, and the history of hospitals. The 2″ by 2″ Kodachromes available from The Ciba Company are used in medical science periods to illustrate gross normal structures. Since large still images are produced, each may thus be studied and discussed for extended periods of

Hospital administration students receive practical instruction in medical science.

* *Dale, Edgar; "Audio-visual Methods in Teaching", page 76.*

time.

This department also uses a "Vu-graph" or over-head projection apparatus which combines the advantages of the slide and the blackboard. The slide is placed under a wide moveable transparent tape before the instructor who may write interpretative notes upon it, as he lectures, and these also appear on the screen — while the speaker still faces the audience.

Film Strips and Films

The film strip is fast becoming one of the most useful of all projected materials and is used when the curriculum unit may be divided into a series of logical steps. Strips are inexpensive to produce, to rent or buy outright, and they show great promise for future development. Here again, a still image is produced which may remain on the screen as long as required. We use a series of these film strips in teaching medical science; and have produced the first of what we hope will be a series for use in teaching departmental management.

Silent and sound educational films are used frequently to introduce or supplement particular units of study. Many films are available on either a loan or rental basis and may serve any one or a combination of three purposes: to demonstrate skills, to portray attitudes and relationships, and to present information.

Sponsored films are gaining in popularity and are being used more and more as an educational medium. Although the name of the film and its product still appear as advertising, the newer sponsored film places more emphasis on the use to which the product is put in the hospital, thus it is highly instructional. However, no film is educational unless it is properly introduced and presents information specifically related to the subject under discussion. It must be integrated with other materials to present a unified whole in the study. The National Film Institute in Ottawa makes available copies of films (from the Bacon Library of the American Hospital Association) which deal with many aspects of hospital administration and operation.

Although the potential value of television as an educational medium is powerful and shows great promise, the cost of production and reception of this type of audio-visual material is as yet very high. In June, 1949, an interested audience in a Pennsylvania hospital watched via television an operation being performed in the same building but on a different floor. Within recent weeks, television audiences across the continent witnessed an actual childbirth in a hospital delivery room. Newly constructed hospitals affiliated with a university are providing for the day when television will be used. In universities teaching hospital administration, we may envision the day when field trips to hospitals will be obsolete and students may "visit" the hospital by "video".

Conclusion

As I said earlier, we are convinced of the merits of audio-visual aids in teaching hospital administration and I believe that the limitation in the use of such aids is one more of vision than of money, materials, or equipment. Teachers need training in the use of the materials and this, with the qualities of imagination and initiative, should stimulate the use of these teaching aids in an increasing number of adult classrooms. Audio-visual aids are not new — it is just that we are not always alert to their value. Perhaps the future can best be prophesied by our adult students who, exposed to these aids, evaluate the results and apply them in their own teaching field. It is a matter of time; but the change seems inevitable and the future looks promising.

The author is pictured above in a special "display" room which is equipped with many types of audio-visual aids.

Stepping-stones toward

Better Hospital Administration

Donald M. MacIntyre,
Assistant Secretary,
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Toronto, Ont.

THE WORDS of King Solomon, "where there is no vision, the people perish", spoken more than 2,000 years ago, are directly applicable to the hospital field of today. The past three decades have been a period of rapid change, both socially and economically, and changing conditions are a challenge to the vision, the ambition, and the knowledge of everyone engaged in the promotion of better care for the sick and injured.

If we are to achieve our objective of better care for hospital patients, then we must devise improvements in the administration of our hospitals. One of the best ways to ensure efficient administration is to see that those individuals charged with the responsibility of operating hospitals have a good understanding of the basic principles involved. By definition, principle is "fundamental truth" or "primary or basic doctrine". It is here proposed to discuss the steps that have been taken and are being taken to make the fundamental truths concerning the operation of hospitals known to those who are engaged in hospital work. In doing so, let us first glance back over the past 30 years.

Apprenticeships

Up to the 1920's, almost the only educational resources in the hospital field were a few individual hospitals, the administrators of which were interested not only in their own institutions but in the field at large and who made their hospitals centres for the training of younger men and women through apprenticeship. In Canada, we think immediately of the late Dr. A. K. Haywood (Montreal General Hospital and later the Vancouver General Hospital) whose record in preparing young men for successful careers has not been equalled. In the United States representative hospitals in this category are: Massachusetts General Hospital, Boston; Johns Hopkins, Baltimore; and Mount Sinai, New York, to mention but a few. It was recognized at that time by the same men who gave their time so unsparingly to the training of others that apprenticeships were very limited in value unless they were properly organized. That is, there was required a full and well-defined rotation of duty and responsibility supplemented by suitable business and technical instruction. Moreover, by this time the apprenticeship method, as such, had disappeared as a method of training in medicine and nursing; it had almost been superceded in the legal profession; and, for skilled workmen such as machinists, it was largely being replaced by technical courses. The result was that leaders in the hospital field proclaimed the need for really adequate training courses, to be provided by educational institutions.

Short Courses

The next stepping-stone was the short course, designed primarily for persons already in the hospital field. A number of universities were interested in the development of such courses in administration but most of those started at that time were of an experimental nature since the needs of the hospital field were not clearly known. Some universities instituted courses not in administration, as such, but in nursing, accounting and/or business administration. McGill and Toronto, for example, offered courses for graduate nurses designed to prepare them to act as instructors, supervisors, directors of nursing, and as superintendents of small hospitals. (New York University offered an early course in hospital and institutional management; while Columbia offered a summer course in out-patient administration in 1919 and in 1920.) In 1926 the University of Western Ontario offered a certificate course in hospital administration in its School of Public Health. However, there appeared to be no demand for such a course at the time and I understand that only one student received this certificate. These are but a few of the short courses offered about 25-30 years ago, but they serve to illustrate the interest being taken by educational institutions.

Complete Curricula

The first major attempt to draw up a more or less complete curriculum for the training of hospital executives was sponsored by the Rockefeller Foundation. A conference of representatives from interested groups in both Canada and the United States was called and a committee on the training of hospital executives established. Dr. W. C. Rappeleye, now dean of the Faculty of Medicine at Columbia University, prepared a report in 1922 which recommended the curriculum content for an entire academic year. Stimulated by this report, Marquette University, Milwaukee, Wisc., drew up an extensive program organized as a college of hospital administration. The college offered an undergraduate and a graduate curriculum in hospital administration, a "short course" of two weeks for hospital people already in the field and a similar summer course of six weeks' duration. This program was evidently too far advanced to maintain a satisfactory educational standard in view of the facilities available. It lasted approximately three years, with the last class being admitted in 1927. About the same time, Antioch University, Ohio, offered a combined apprenticeship and university course, where the student took undergraduate courses in accounting, statistics, organization, et cetera, and then proceeded to a selected institution, on an apprenticeship basis,

From an address presented at the 19th annual convention of the Ontario Conference of the Catholic Hospital Association, Toronto, Oct., 1952.

to make practical application of the subject.

Davis Report

We now move on to the next important development, which was again sponsored by the Rockefeller Foundation. This time a report, entitled "Hospital Administration: A Career", was published by Michael M. Davis, well-known writer in the field of medical economics. The report pointed up the need for trained administrators and outlined formal methods of training to achieve this end. It was published in 1929. The following year, Duke University, Charlotte, N.C., started a two-year apprenticeship program associated with its school of medicine. The program has become well known and is still in operation. During the intervening years, this program has provided training for the executive personnel of hospitals located in that part of the United States and especially those areas in which the Duke Foundation is primarily interested. This two-year program is for students with a university degree, usually business administration.

For our next stepping-stone, we go to the University of Chicago in the year 1934. At that time, an excellent experimental graduate course in hospital administration was started in the graduate school of business. This experiment was made possible by a grant from the Rosenwald Fund which continued until 1937 and, after that time, the course was assisted financially by the Commonwealth Fund for a few years. Registrants in this course were required to hold either a bachelor's degree, or a doctorate of medicine. The student applied for a master of business administration degree, with provision being made for a Ph.D. degree. Not only did these students devote a year to academic study at the University but they were also required to spend from six months to a year in an administrative internship. Dr. A. C. Bachmeyer, director of the University of Chicago Clinics, became the first director of this new course and held that position until he retired a year or so ago.

About this time, it became necessary for the American College of Hospital Administrators to make a statement concerning the validity of the concept of hospital administration as a separate and independent career, as opposed to the view that hospital administrators should be recruited from other vocations or occupations by a self-selective process. The Committee on Educational Policies of the A.C.H.A., of which Dr. Malcolm T. MacEachern was the chairman, examined the problem of training for better hospital administration and in 1937 published a report entitled "University Training for a Hospital Administration Career". In the foreword of this report, written by Reverend Alphonse M. Schwitalla, S.J., the American College of Hospital Administrators announced its policy that hospital administration is to be considered validly as a special profession. This report concurred in the type of training started at the University of Chicago and set out basic principles concerning the educational preparation of hospital executives. It paved the way for the future development of this type of training. In 1943, just nine years after the start of the program at the University of Chicago, a similar course of training was established in the evening division of the School of Commerce at Northwestern University. This program developed later into the course as we know it today at that university, with Dr. MacEachern as its director.

In 1945, the Joint Commission on Education of the American Hospital Association and the American College

(Continued on page 74)

How, What, and Where?

Extension Course in Medical Records

The Canadian Association of Medical Record Librarians and the Canadian Hospital Council jointly announce that an extension course for the training of personnel engaged in medical records work will be available in the fall of 1953.

Conditions of eligibility

(a) Male and female candidates alike are eligible.

(b) Candidates must possess a junior matriculation, or its equivalent.

(c) Candidates must be employed in medical record work for the duration of the course.

How the course will operate

The complete course is of two years' duration. Each year will consist of two stages, a "home-study" and an "intramural" session. During the "home-study" session, lessons will be mailed to the student. Each lesson will contain an assignment which the student will complete and submit for marking. The "intramural" session consists of one month's training in a medical record department of a hospital approved for this type of instruction. These hospitals will be located in both eastern and western Canada.

What the student receives

Upon satisfactory completion of the course, the student will receive a certificate from the Canadian Association of Medical Record Librarians. A preliminary certificate will be awarded by the association at the end of the first year. Neither certificate is to be confused with the certificate of registration (R.R.L.) now granted by the Canadian Association of Medical Record Librarians. Further qualifications are necessary to apply for registration.

What it will cost the student

The tuition fee for each year of the course is $100.00. Other expenses will include the purchase of certain textbooks, postage, writing supplies, et cetera, the total of which should not exceed $25 - $30, as well as transportation and room and board in connection with the summer sessions.

Where to apply

Application forms and further information may be obtained by writing to the Secretary, Committee on Education, Department "E", Canadian Hospital Council, 280 Bloor Street West, Toronto 5, Ontario.

An Answer to a Shortage

Extension Course for Medical Record Personnel

Marjorie Riddell, R.R.L.,
President-elect,
Canadian Association of Medical Record Librarians,
Toronto, Ont.

SINCE you are now scanning these lines it is fair to assume that you have already read the editorial comment which appears in this journal concerning the extension course to assist in the training of medical record personnel. Something concerning the background of this venture from the standpoint of the medical record librarian might perhaps not be amiss to round out the picture.

In Canada at the present time, if one wishes to be a registered medical record librarian, one must have attained the age of twenty years; have senior matriculation or the equivalent educational standing in the various provinces; or be a graduate of a school of nursing recognized by a provincial board of nurse examiners, or hold a first-class teaching certificate; have proficiency in shorthand and typing; have successfully completed training in an approved school for medical record librarians or have been actively engaged for five years in a medical record library of an approved hospital; and pass the examination set by the Canadian Association of Medical Record Librarians.

It is an unfortunate truism that a pronounced shortage of qualified medical record librarians now exists both in Canada and the United States. This shortage has reached serious proportions and the need for properly qualified record personnel in our hospitals is increasing year by year, not diminishing. Hospital administrators will appreciate that such conditions, if allowed to persist, will have a serious effect on the medical records in our Canadian hospitals. At present the number of individuals registered annually with the Canadian Association of Medical Record Librarians does little more than meet the demand for replacements in the field. The limits of the real and potential need are difficult to define.

A further problem also exists. There are many people looking after medical records today who have had no specific or formal instruction; they have "just growed" into their positions. This is true particularly of the hospitals in the more rural communities and is true, too, of some of the medical record departments in the urban areas. In the majority of instances it would be quite impossible for these people to leave their positions to attend one of the approved schools for the year such training entails. The time factor and the financial outlay involved would preclude this, especially as many of these people, through no fault of their own, lack the wholehearted support of their hospital administrator and the medical staff.

The Canadian Association of Medical Record Librarians and the Canadian Hospital Council have given careful consideration to these two problems and it was felt that something concrete and very worthwhile could be accomplished immediately by establishing an extension course by correspondence for medical record personnel. Financial assistance has been generously provided by the Kellogg Foundation to enable these two bodies to initiate a course of two years' duration, with an in-training period of one month during the summer of each of the two years. It is hoped that this course will begin to alleviate the existing difficulties and will assist those who are unable to attend an approved school for medical record librarians. The successful completion of this course would, therefore, entitle those students who can comply with all the requirements of the Canadian Association of Medical Record Librarians to sit for their R.R.L. examinations, provided they have a minimum of three years' experience which will include the two years of extension studies. These three years are, therefore, roughly equivalent to the one year of training in an approved school for medical record librarians.

Applicants who have junior matriculation or wide experience in medical record work will be admitted to the extension course. If the educational background of the student does not meet the academic standard for writing the registration examination for the R.R.L. certificate, such a student would, nonetheless, be much better equipped to work in a medical records department. She would receive a Canadian Association of Medical Record Librarians' certificate indicating completion of this course of training.

The curriculum of the first year of such study will acquaint the student with basic principles and practices in medical record keeping sufficiently well to meet the needs of the majority of small or medium-sized hospitals or fit them for junior positions in the larger institutions. The second year of study will deal with more advanced principles of record work and will prepare the student for full responsibility in a department. Those with sufficient educational qualifications and experience (in addition to receiving the second-year certificate awarded to all successful candidates) may then sit for their R.R.L. examinations.

In either event, by taking advantage of this training these people will be of much greater help to their hospitals, to the patients, and to the whole medical field. The accurate and intelligent keeping of records is the primary requisite for all proper assessment of treatment, all vital statistics, and all progress in the war against disease. The course of training will also render a real service to the students enrolled by raising their status and increasing their usefulness in the medical records field. Two points should be emphasized. First, the extension course in no way replaces the existing formal one-year courses offered in several centres. Second, although sponsored by the Canadian Association of Medical Record Librarians and the Canadian Hospital Council, with financial assistance from the W. K. Kellogg

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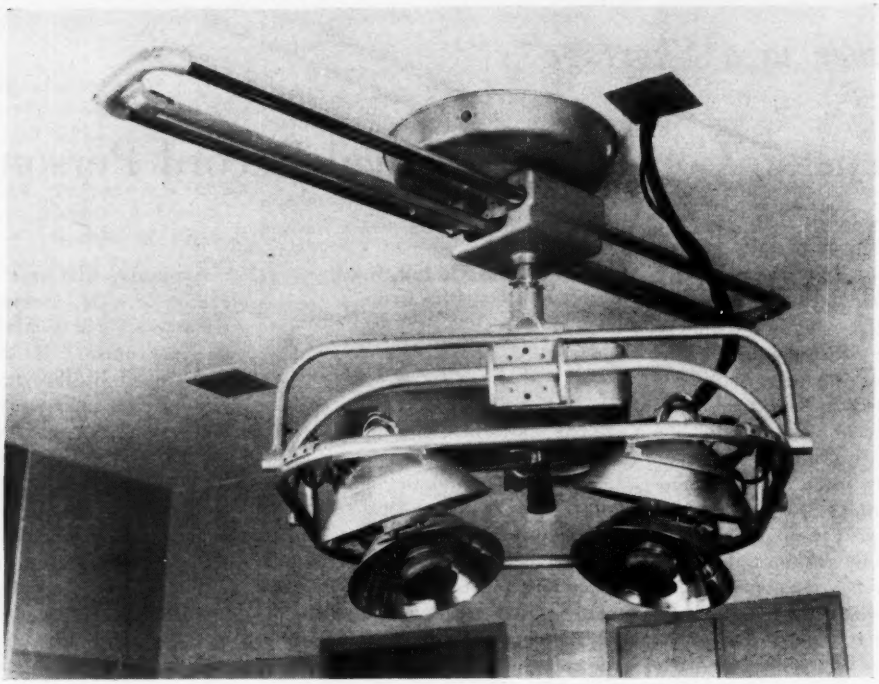


O.R. Light With Colour Camera.

Colour Television—

a dramatic teaching medium

Bruce Babcock*,
Rochester, N.Y.

WHILE probably all of us have heard of the use of the modern miracle of colour television in surgery, there are undoubtedly many who, through failure to appreciate its tremendous potential as an educational tool, have not fully realized its broad adaptability to the surgical and medical fields. To sum up in a few words the outstanding advantage of this revolutionary teaching medium, it has been said that colour television enables " all to see where few can be".

Whether it be, for example, in the restricted area of an operating room, pathology laboratory, anatomy class, fluoroscopic room, or even at the eyepiece of a microscope, television now makes available to the teacher the means of showing to an entire class with equal clarity, and in a single lecture, the most minute detail which formerly had to be presented over and over again to successive small groups.

In Surgery

Let us consider specifically the most widely-recognized application of colour television, its use in the televising of surgical operations. Transmitting from the operating room to receivers located in the medical school classrooms or auditorium, it is now possible through this medium to present to a student group of any size this type of instruction at one time. Contrast this method with the traditional method where two or three students are actually in the operating room beside the surgeon as he works, while the balance of the class must of necessity view the operation from a gallery or amphitheatre. From the latter comparatively remote vantage point, little of actual technique can be seen and too often the view is obstructed by personnel around the operating table. Even the few students alongside the surgeon frequently must depend primarily on the surgeon's comments for instruction inasmuch as the operating field, because of its small size, is not clearly revealed. Thus, because of physical limitations, students in the operating room itself are exposed primarily to atmosphere and operating room procedure rather han to surgical technique.

With a colour television camera mounted in an operating light, the camera lens is trained along the focal axis of the operating light beam and it is obvious that any area illuminated for and seen by the surgeon can be picked up by the camera. The potential capacity for teaching purposes of a colour picture taken from this vant-

* *The author is with the television department of the Wilmot Castle Company.*

age point is immediately evident. The evolution of a surgical operation is so clearly portrayed that it leaves nothing to the imagination of the viewer. Sections of the anatomy, with which the surgeon comes in contact during the operation, are depicted with remarkable clarity and in their natural colours, with the result that the student's instruction is as comprehensive as though he were viewing the operation through the surgeon's own eyes.

The use of an intercommunication system in conjunction with the program loud-speaker installed in the receiver not only enables the surgeon to lecture as he works but, also, establishes two-way communication between the classroom and the operating room, so that questions may be asked and answered at any point where some stage of the procedure may not be entirely clear.

Other Applications

Although the use of colour television in surgery was the first and has been certainly the most spectacular application, this particular use is but one of the almost unlimited possibilities. It has application in the teaching of obstetrics and gynaecology and, through the employment of a portable camera, can bring similar advantages to the teaching of gross pathology, anatomy, and physical diagnosis. Spectacular results have been achieved in telecasting pictures directly from the eyepiece of a microscope. In the fields of medicine and more especially psychiatry, the lecturing physician can work without restraint since the medical students need not be physically present to embarrass the patient. The traditional privacy of physician and patient is thus maintained during the diagnosis; and the teaching benefits under such circumstances are immeasurably greater than they are in a clinic where the patient is necessarily under strain because of his natural awareness of the presence of numerous outsiders.

History

Having thus considered briefly some of television's possible applications, let us look backward briefly at its beginning and development. In this connection, it may be a surprise to many to learn that the use of television in surgery is not new, the first successful experiment with this medium having been conducted six years ago at Johns Hopkins Hospital in Baltimore in February of 1947. This earliest practical demonstration was televised in black-and-white over a closed circuit system, the picture signal from the camera in the operating room being transmitted by cable to receiving sets within the hospital. Despite the understandable imperfections of that initial demonstration, television was instantly recognized as an outstanding advance in the teaching of surgical technique.

Only a few months later, a black-and-white telecast was made from a New York hospital to a gathering of doctors at the Waldorf Astoria Hotel in the same city. This foreshadowed the inter-city programs of the future and it was realized that here was probably the best answer to the problem of bringing the latest surgical techniques to doctors all over the country.

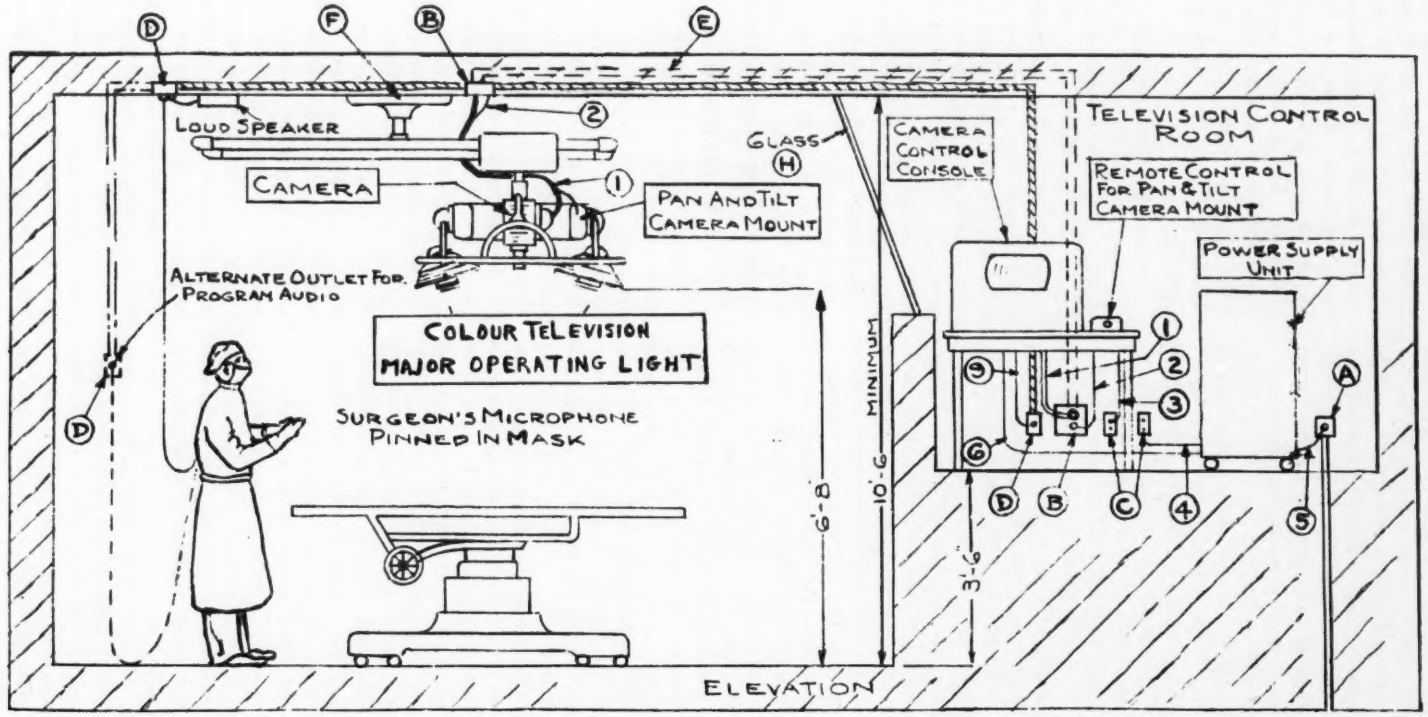
On May 11, 1949, an important advance was made when the first operation ever televised in colour took place at the University of Pennsylvania Hospital in Philadelphia. This landmark in televised surgery was made possible through the co-operation of Doctor I. S. Radvin, Professor of Surgery, at the University's Medical School; Smith, Kline and French Laboratories, a local pharmaceutical manufacturer; and the Columbia Broadcasting System Laboratories. This advent of colour in television opened the way to overcoming the handicap of the black-and-white picture which, in presenting an image in varying shades of grey, failed to differentiate instantly and easily between arteries, tendons, nerves and tissues. Furthermore, the monochrome picture failed to present to the student the colour of the exposed organs which are frequently a prime factor in enabling the doctor to make a correct diagnosis. Add to this the additional fact that colour gives a third dimensional impression, making every minute detail of an operation instantly perceptible and easily understandable, and it will be seen why, for teaching purposes, black-and-white television had fallen short of ultimate requirements.

At this time, Smith, Kline and French Laboratories commenced their now well-known series of convention programs, using the new medium of colour television in connection with the promotion of their line of ethical drug products. On June 1, 1949, they put on their first program at the American Medical Association convention in Atlantic City. Since that time, G. F. Roll, the company's public relations director, estimates that almost one-quarter of a million persons have witnessed these demonstrations at some forty major medical meetings in the United States, Canada, and France. It is estimated that probably 75 per cent of the doctors in the United States have viewed a Smith, Kline and French colour television program at one time or another. Eleven exhibitions are already planned for the United States in 1953, ranging from Chicago to New Orleans and from New York to Salt Lake City.

During the week of June 13-17, 1949, televised surgery made its initial appearance in Canada with the telecasting in black-and-white of a series of operations performed at the Saskatoon City Hospital. Two years later, colour television was seen in Canada for the first time when Doctor Gavin Miller performed a sub-total gastrectomy in an operating room of the Royal Victoria Hospital, Montreal, during the annual meeting of the Canadian Medical Association. This program was relayed to receivers in the Mount Royal Hotel, where some 1,500 surgeons viewed the ninety-minute operation.

O. R. Light With Camera

A second advance was made in September of 1949 when the Wilmot Castle Company of Rochester, N.Y., completed the first major operating room light specifically designed to accommodate a television camera. Up to this time, a serious disadvantage of televised surgery had been inherent in the temporary nature of the various programs. This entailed bringing into the operating room the camera and special lighting equipment, together with the television technicians. It is a demonstrated fact that additional personnel entering the operating room during surgery increases the hazard to the patient in proportion to their number. For this reason, the presence of persons other than members of the actual surgical team, particularly lay personnel, is highly undesirable. As a result, the telecasting of surgical procedures with temporary equipment has always been a demonstration of attainable results rather than of practical methods. Thus it is apparent that a really practical application of television to surgery required the design of a camera compact enough to be installed within a major operating light, and capable of being operated from a remote location.



Legend

1. Camera cables requiring 2" conduit.
2. Remote control cable requiring 2" conduit.
3. 115 volt, 60 cycle, single phase AC power at 75 W.
4. 115 volt, 60 cycle, single phase, 3 wire AC power at 1.8 W.
5. Signal cable, requiring 1" conduit.
6. Signal and power cable.
9. Program audio and intercom cable, requiring ¾" conduit.

A Wall outlet box, 4" x 4" x 2⅛".

B Wall and ceiling outlet boxes, 6" x 6" x 4".

C Wall outlet box, 4" x 2⅛" x 1⅞".

D Wall and ceiling outlet boxes, 4" x 2⅛" x 1⅞".

E The two camera cables are single length cables between the camera and camera control console and cannot exceed 30 feet. Distances to power supply unit (if remote from camera console) or receiver(s) are not critical. Special cable is required for receivers and more than 500 feet from camera control console.

F Ceiling mounted fixture. Special provision will be necessary for ceilings over 12'.

H If television control room is not totally enclosed, outlet boxes must be located at least 5' above operating room floor level.

This goal was realized, as we have seen above, in 1949 through the combined efforts of the Remington Rand Company, who manufactured such a camera, and the Wilmot Castle Company, who built an operating light which combined the function of surgically lighting the operative field with that of illuminating the field for television projection. The fixture incorporated six 100 watt bulbs, each with an individual reflector, mounted around the periphery of a 39½" diameter housing. This housing was some 31" deep and accommodated the Remington Rand black-and-white camera, centrally located in a 13" diameter well in the centre of the light. The camera was equipped with a dual lens turret mount for the transmission of the small or large field and the camera control operator was able to switch lenses and to focus the camera from a remote location. The surgeon was equipped with a special brush-type microphone pinned within his surgical mask and a small hearing-aid type earpiece. These, in conjunction with a portable microphone in the viewing auditorium, provided an intercommunication system which gave ready contact between the surgeon and his audience. Specifically designed for the University of Kansas Medical School at Kansas City, Kansas, this light and camera assembly received nation-wide publicity at the time of its installation, because of its epochal contribution to surgical teaching.

O.R. Light With Colour Camera

Colour television at this point still had not been sufficiently developed to enable its incorporation into a special operating room light, but this next big stride was obviously only a question of time. Two years later, as a result of close collaboration between Columbia Broadcasting System Laboratories, Remington Rand, Inc., and the Wilmot Castle Company, the combining of a colour television camera into a remarkably compact yet highly flexible unit was finally achieved. This unit was installed at the University of Kansas Medical School and was placed in operation on November 29, 1951.

The colour television camera included several important refinements over the earlier black-and-white model. Foremost of these was the design of a remotely-controlled camera mount which made possible the positioning of the camera by the camera control operator from a remote location. A third lens was added to the camera to give greater picture flexibility, the three lenses giving viewing fields approximately 21" x 16", 12½" x 9½", and 5½" x 4½". The remote focusing and lens switching features of the earlier black-and-white camera were all, of course, retained. Presenting a distinct departure from the earlier model, the operating light employed an open frame mounting for four 150 watt bulbs, each with its own reflector. The enclosed housing of the initial fixture thus was eliminated, making possible the cooler operating temperature desirable with a colour camera and also tremendously simplifying access to the camera for routine servicing. Of particular importance in the design and development of the operating light, was the necessity for ensuring that the camera would "see" only those colours seen by the human eye. The image orthicon or "picture taking" tube of the colour television camera has a response in the infra-red region. With ordinary incandescent lighting this extra signal, unseen by the human eye, will be picked up with resulting contamination of the true colours. To counteract this, the Castle operating light uses special colour correcting filters which provide illumination very closely approximating daylight and ideal for colour television.

Besides the installation at the University of Kansas, two other colour television units are currently in operation in the United States; one having been installed at the University of Chicago in December, 1951, and the other at the University of Pennsylvania in September, 1952. An additional colour unit is in operation at the Hôpital Cochin in Paris, France.

The Installation

Let us turn now to a consideration of the equipment necessary for an operating room colour television installation. The accompanying drawing shows the relationship of the following basic equipment units.

Camera

The colour television camera is, of course, the picture-taking component of an installation and is comprised essentially of a lens, a colour filter drum and drive, an image orthicon or picture-taking tube, and a pre-amplifier for amplification of the video or "picture" signal, which is transmitted from the camera through the camera control console to the receiver. The camera, which may be focussed remotely, is surprisingly compact, being 23" wide by 7¼" high by 6¼" deep and weighing only 41½ pounds. Three lenses are included in a turret mount and any lens may be selected by remote control.

Camera Mount

The pan and tilt camera mount accommodates the colour television camera; the mount, in turn, being secured centrally within the frame of the operating light. The unit is driven by two remotely controlled electric motor and sprocket drive assemblies, totally enclosed within the camera mount casting. This makes possible the remote positioning of the camera lens anywhere within a 30-degree arc measured in any direction from an axis originating at the camera lens and extending through the focal point of the operating light beams. Control of the motion of the mount is actually governed by a joy-stick type control, operated by the control technician from the television control room.

O.R. Light

The colour television major operating light is a ceiling mounted type fixture with a specially designed lamphead assembly mounted on a 7-foot rotating track. As we have already seen, this light was specifically engineered for the colour television camera and camera mount, and incorporates four individual lampheads. The light requires a minimum ceiling height of 10' 6" although, for ceilings as low as 9' 6", a special fixed track installation is available.

Control Console

The camera control console is primarily a monitoring receiver which receives on its kinescope or picture tube the signal transmitted from the camera. This picture is adjusted by the control technician for colour fidelity, contrast, brightness and focus, and re-transmitted to the receiver. Controls for the remote focusing and switching of the camera lenses are located at this unit. It will be noted from the accompanying drawing that the camera control console is located in a television control room elevated above the operating room floor level in order that the control technician will be able to look

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for hospital personnel —

Merits of In-service Training

Lola Wilson,
Registrar,
Saskatchewan Registered Nurses' Association,
Regina, Sask.

TODAY there is a need to increase and to give better in-service education in our institutions. We believe there is a general recognition of this need but, under pressure of work, we are inclined to close our eyes to it with the idea that we'll do something about the matter when we have more time. Perhaps there are even some who feel that this situation requires attention in the large hospitals but has no bearing on the small rural hospitals of 10 to 15 beds.

Job satisfaction is necessary if we are to have happier, more stable staffs, in our hospitals. Growth and development of the individual are essential to job satisfaction. In order to bring about this growth and development we must have in-service education for all those who are connected with our hospitals, from board members down through the ranks. The idea "incentive for growth must come from within" is very well understood by all of us. We also know, however, that many people are not particularly interested in such growth even though it may be to their own best interests to foster it. Hence, it is our task to enrich and extend in-service education to such a degree that even the most disinterested member of the group will catch some of the fire of our enthusiasm. The pattern for such a program will vary, of course, with the size of the hospital and be geared to fit the individual situation.

Types of Hospitals

The hospital conducting a school of nursing has, of course, an in-service education program geared to fit the needs of the school. This program extends to all professional staff members to a greater or lesser degree depending upon their relationship and responsibility to the educational program. However, in the hospitals conducting the largest and often the most highly rated schools of nursing, there is a constant complaint that the majority of staff are not interested in any element suggestive of an on-the-job program for over-all educational betterment. The in-service program, as it is considered in this article, has no relationship to that program set up for students in a hospital associated with a school of nursing or with nursing alone.

In the group of hospitals, judged "less educationally minded" because they lack a school of nursing or do not accept interns for experience, we find both the large and small hospital. It is only through the most heroic efforts that any semblance of an in-service program of education is carried on even by the professional groups. Of course we must not fail to recognize the fact that learning takes place naturally during work experience whether we will it or not. Therefore, to a degree, there is a sort of in-service program being carried on in the natural course of each day's work, though it has neither plan nor direction. Planned effort can guide this learning into more productive channels if it is directed towards certain goals.

How to Begin

First of all, one must sell the idea of an improved in-service program of education to the superintendent of the hospital—if he or she does not initiate the idea. It will then be necessary to develop a skeleton program, so that there is something concrete to work with. Do not forget when planning to include every member of the hospital staff from the maids, nurses' aides, orderlies, office workers, right on through to the board of directors. The content of the teaching will have to be consistent with the abilities of the group but each and everyone should have a part in the program.

The next line of attack is to get permission to use staff time for the program as well as the facilities of the institution. Staff training does take the time of workers away from their routine duties of the day. This is the greatest objection to be overcome. It requires a great deal of faith in the virtues of such a program to hold to the line when pressure of work mounts. More pressing duties tempt one to steal time from in-service training in order to deal with the seemingly more pressing duties of the moment.

If the hospital possesses an educational director, he or she may be the logical one to assume the leadership of the over-all in-service program. However, many hospitals will not be fortunate enough to have such a person on their staff. In all cases the most capable member of the staff will be the one who will give leadership and direction to the program. However, the spirit of the undertaking will rest in the hands of the hospital super-

From an address presented at the Saskatchewan Hospital Association convention, Saskatoon, October, 1952.

intendent who must co-operate to the fullest possible extent if the undertaking is to be successful. Indeed, he or his assistant may very well be the one to undertake direction of the project. In hospitals directed by the sisterhoods this is probably the authority from which the desired leadership will stem.

It is hoped that in all instances we can rule out petty jealousies which might be associated with the appointment of a leader. Again we emphasize that the person most fitted should assume this responsibility. Such a leader must have progressive ideas and training. Tact, efficiency, ability to organize and get things done, must be general characteristics. It is necessary that this person should have the confidence of the staff and be liked and accepted by each member.

The leader must be the general over-all organizer who acts as the guide and consultant. When active participation by the staff becomes apparent the leader more and more relinquishes the role first assumed — that of program manager. As the staff takes on more responsibility, he becomes the adviser. It is the adviser's job to spot weaknesses and any evidence that the program is not developing as it should, according to the objectives set. However, by-and-large, he goes into retirement insofar as outward appearances are concerned.

The very word, "education", indicates that this program is not haphazard but, rather, planned with a consciousness of the need for growth and development of the entire staff. It also indicates group planning and participation since the word, "staff", is inclusive and not selective. This is democratic activity since the worker, supervisor, instructor, director, chiefs of services, indeed all members of the hospital team share jointly in the learning responsibility.

Objectives

Dr. George T. Palmer of the United States Public Health Service has said that "the primary goal is to develop people". It is quite obvious that if we improve people we have accomplished the first step toward an improved program. It is the leader's responsibility to decide what skills and qualities he wishes to see developed and then set up a program to try and attain these desired improvements. In setting about this it is well to make an effort to discover the wants of the staff. The honest attempt to bring about satisfaction of these wants will bring a direct response from the people concerned. Through this means the actual avenue by which your objectives are going to be reached will be apparent—or at least glimpsed.

So, in this business of in-service education, it is evident that we desire something more than to increase the worker's knowledge in his particular field. We desire as well to develop in every worker a deep personal interest in his job, to recognize the need for alertness toward improvement brought about through trial and testing, to be unafraid of constructive change, and to learn how to get along with people.

Through all this we expect to increase each staff member's knowledge of the over-all workings of the hospital; the part each department plays; something of the problems of each department; the personnel policies of the hospital, and how they are set up; the lines of authority in the hospital; the place of the hospital in the community both as a curative and as a public health agency. In addition, we anticipate the fostering of better public relations for the hospital by developing each and every worker into an active public relations and propaganda officer.

The Staff and their Needs

Beyond remuneration and security, there are six major wants on the part of each staff member regardless of his position:

1. to be respected as a person
2. to receive recognition
3. to have his ideas welcomed
4. to be regarded as a responsible member of the team
5. to experience satisfaction in his work
6. to be thought important enough to be included in planning and carrying out new programs.

Opportunity for self-expression and participation in the planning of a program cannot be over-emphasized. Every member of the group will not respond equally. However, if opportunity is provided there will be a certain growth even in the most disinterested, after a time, if the opportunities are repeated at frequent intervals. When members of a staff begin to assume active participation in the program it ceases to be the director's program and becomes the staff program. This tends to retain interest in the program, for each individual taking part now thinks of it is *his* program and hastens to help it along by more support in carrying it out.

Division of the Group

In each hospital, the doctors have some type of educational program which they carry out among themselves. However, it is very probable that many of them will want to contribute in some way to the program of in-service education for they are among the staff members who are most likely to recognize the many benefits that can be expected in hospital service from such a program. The entire program should be divided into sections; each suitable to the group to whom the program is directed.

The board of directors should be given an outline of the program with sufficient detail so that they will be aware of the content for each section of the personnel. Some instruction as to the benefits that can be expected from an in-service program of education should be given to the board. Only through a frank discussion with the board concerning the educational needs of the staff can we hope for their support as well as the materials and necessary increase in the budget.

Each group of the professional staff must have a program, with each phase pointing to the desired objectives. Nurses, pharmacists, x-ray technicians, laboratory technicians, dietitians — all must be a part of the over-all planning. They can, of course, have much of the program in groups which contain mem-

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Where
Women
Serve
Women

Women's College Hospital, Toronto

Raises Funds for Expansion

Photo courtesy of The Photographic Survey Corporation Limited, Toronto.

A specially-formed student nurses' choir from the Women's College Hospital broadcasted a fifteen-minute program of carols over radio station CFRB, on December 25th, in aid of the hospital's building fund.

WOMEN'S College Hospital, Toronto, Ont., the only hospital in Canada staffed entirely by women doctors, appealed to the public last month for $4,150,000 to provide new construction for the hospital and renovate the existing structure. The purpose of the building program is to double the hospital's bed capacity by the addition of a new wing, which will also house the out-patient department, new laboratories, a special psychiatric unit, and a small surgical recovery ward. A second wing will provide space for enlarged kitchen, dining, and laundry facilities. A new nurses' training school and residence will be built on Grosvenor St., adjoining the hospital, to replace seven antiquated dwellings now used to accommodate the nurses.

The present 160-bed hospital was opened in 1935 and is presently so overcrowded that beds are frequently placed in the corridors. Despite this, and other handicaps, the hospital has maintained its tradition of "service to women by women" and has an unequalled low record for maternal deaths. In 1951, 2,484 babies were born in the hospital without the loss of a mother.

By mid-January the fund had reported $1,606,957 in gifts from corporations and individuals. Grants will also be forthcoming from the provincial and federal governments, the City of Toronto, and the County of York. An outstanding gift was $150,000 from the Atkinson Charitable Foundation to instal new laboratories in the hospital, including an endocrine laboratory. The new additions have been designed by Marani and Morris, Architects, Toronto, with J. E. Assheton Smith, Toronto, as Associate Architect.

A. G. Ferchat, A.T.C.M., assistant public relations director of the O.H.A., discusses the carol program, which he directed, with (left to right) Jessie E. Young, director of nursing, Women's College Hospital; Judith Kingsford; Mrs. Charles McLean, chairman of the hospital's board of directors; and Elizabeth Reeve.

Canada Advances in

Medical Education

A sketch of the first building of the McGill Medical Faculty on the university grounds is shown here. Erected in 1872, this building was destroyed by fire in 1907.

F. H. Fish, M.D.,
Calgary, Alta.

THE DEVELOPMENT of medical education in Canada makes, necessarily, a short history. Yet it covers a period in the history of our country which includes not only the hardships of the pioneers but also encompasses the more recent and dramatic discoveries in diagnosis and treatment.

When it is considered that less than 130 years ago the first medical schools were opened in Canada, well-deserved praise is merited for the part Canadians have played in recent medical discoveries. It is a tribute to our place in the scheme of international brotherhood — which is the finest combined effort in the world — that the discoverers of insulin were awarded, for the second time only in North America, the Nobel Prize in Medicine. For members of a young nation such as ours to receive world recognition speaks well for the basic training received in Canadian schools.

Naturally enough the growth of our system of medical education has not been an internal development. We have been in the happy position of being able to investigate other systems of teaching and to adopt or discard those elements which, respectively, appealed or appeared unsuited to our needs. Thus we incorporated into our schools ideas which had their origins in distant world centres — centres which, during our earlier years, were in Europe. As a consequence, a goodly part of our basic sciences owe their colouring to teachers in charge of well-organized clinics in Great Britain or continental Europe. It will be remembered, for instance, that no farther back than Osler it was necessary for him to go to England, for finishing work in physiology, and to Paris, Berlin, and Vienna, for clinical work with the great teachers before he began his teaching in this country. Let us not forget either that as recently as the early 1920's an eye specialist was not considered worth his salt unless he had attended clinics in Vienna.

One wonders just what the unsettled conditions in Europe, since the turn of the century, have had to do with the swing of the pendulum in medical teaching to the North American continent. We must accept it as a fact that recent developments in medicine, for the most part, have their origins or at least find their development and application chiefly in North America. Whether or not this can be laid at the door of the inexhaustible American energy and financial wealth is another question which will not be dealt with here.

My personal opinion is that we owe more to the swing of the pendulum than we realize. Our foundations being what they are, we are in the position of having the necessary facilities for sound basic work — a thorough grounding never hurts anyone — and our American cousins are still avid to take advantage of these facilities. On the obverse side, we lose sight sometimes of the effect of American stimulus on our thinking. We, in turn, use their post-graduate schools to further our own training. It is a sobering thought that the loss to Canadian teaching is America's gain because of greater clinical and financial opportunity below the 49th parallel.

At the time of the conquest of Quebec and the Treaty of Paris in 1763, the settlers under the old French regime had relied upon army surgeons to supply their medical needs. This condition also obtained under the British but as complications arose following the American War of Independence, it became necessary to set up some sort of standard. Accordingly, the first legislation to deal with the problem was a medical act in 1788, passed in the British Parliament, which provided that no one should practise physic, surgery or midwifery within the towns of Montreal and Quebec without a licence. Licensing examinations were conducted by a board set up by the governor.

In 1783, following the American Revolution, Canada had an influx of settlers — the United Empire Loyalists. Such an influx posed a medical problem for a settlement which had, heretofore, been barely "getting by" with the medical services it possessed. Since it is true that the physician is, by instinct, conservative in his thinking, quite naturally those well established in practice in the American colonies did not move with the Loyalists but determined to carry on their work under the new regime. The medical practitioners who did migrate were for the most part those who had been

Reprinted from the "Historical Bulletin", which is published quarterly by the Calgary Associate Clinic, Calgary, Alta., in conjunction with its medico-historical meetings, Vol. 17, No. 3, November, 1952.

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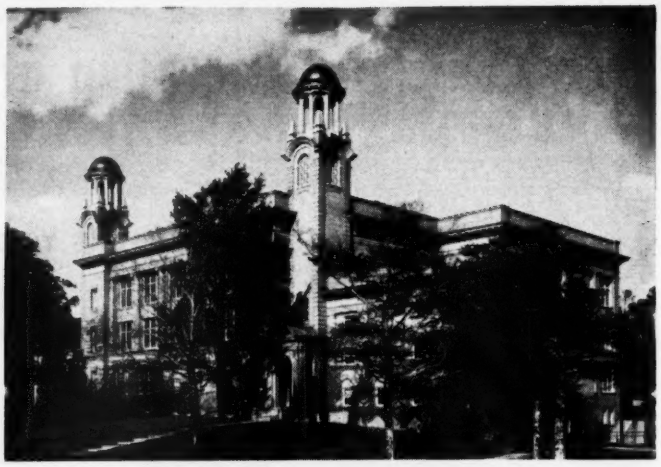
attached to the military forces. It is to be remembered that this was the era of the quack and the charlatan, so licensing and disciplining became major problems. This is undoubtedly the reason for the medical licensing act of 1788. In those years, very few of the immigrants were qualified to practise any form of medicine and those who were usually settled in the towns so that rural areas were very poorly served. The family "doctor book" became a necessity and home remedies flourished. Many today may still recall such home remedies as infusions of bark, sassafras, and others, around which some of our present-day medical superstitions have their origin.



The main building, faculty of medicine, University of Toronto, was opened in 1903

Early Teaching Hospitals

Out of the chaos, which was medicine in the earliest settlements, eventually came order. Here, it is well to mention those heroic women of the Catholic faith who, leaving behind all thought of comfort, came out to the frontiers of New France to establish hospitals, almshouses, and homes for the feeble and infirm from which have grown the chain of modern hospitals which we enjoy today. Theirs was a task, the performance of which was fraught with risk. Yet the task was carried through to a conclusion which deserves the greatest credit from the present generation. It is also true that without the establishment of hospitals, the system of medical education could not have been founded. Apart from the hospital in the town of York, which was built in 1817 and which was the focus from which the present Toronto General Hospital stemmed, and a small Montreal General Hospital of four beds, which was the parent of the present institution, the Catholic hospital system was the only one extant when medical studies were begun in Canada.

The wards in the Sisters' hospitals were opened for teaching, or rather for clinical experience, about 1850 and then only on a pontifical order and with the proviso that if the school (Montreal) "were ever declared to be rebellious to the Church, the engagements would become null and void".

Early Medical Schools

With hospitals open for teaching it was not long before medical schools were established. It is difficult to determine where the first school of medicine to open was located. A school in St. Thomas, Ontario, under John Rolph, published an announcement that lectures would commence in the theory and practice of medicine in July, August, and September, 1824. This took the form of a notice and stated that the establishment was under the immediate patronage of Colonel Talbot and would be staffed by Charles Duncombe and John Rolph. It opened with twelve pupils.

The school in Montreal, on the other hand, while mooted in 1822, did not receive its sanction and charter from the governor-general in time to open before November 10th, 1824*. Twenty-five students attended. It might be said, in extenuation of those from Montreal, that the delay in opening was due more to difficulties of organization than to any display of rivalry in wishing to open at an earlier date. The vicissitudes which were visited upon the institution in Upper Canada did not fall to the lot of the Montreal Medical School, which early in its career became the nucleus of the McGill medical faculty in 1829. This occurred because the teaching institution, which was staffed by men who held appointments in the Montreal General Hospital, lacked a college empowered to grant degrees. The move was probably political too in that it saved for McGill the endowment of the Burnside Estate and the grant of £10,000 left by James McGill with the proviso that a university must be established within ten years of his death. While the charter had been obtained and a skeleton faculty appointed, it had still to graduate personnel from its halls.

Most teaching instutitions in any age are plagued by one common ailment—lack of money. The early schools suffered from this same trouble which resulted in poor quarters for dissecting rooms and laboratories, lack of heat, and all the concomitants which result from insufficient funds. The McGill school had all these griefs and, with an expanding student body, changes in locale were many. Except for a period of five years, from 1845 to 1850, the medical school was not housed on the campus until 1872, when the old Medical Building was opened.

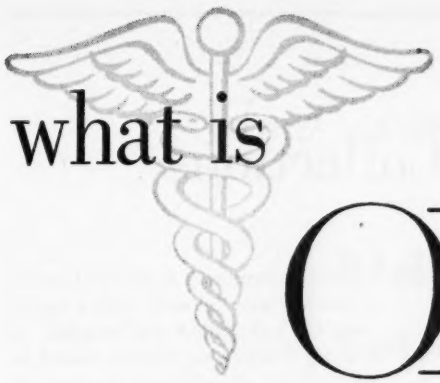
The expansion of the faculty of medicine at McGill was undoubtedly due to the quality of the professional staff. Not only were they well-trained at home and abroad but they were interested in teaching as an art. With the appointment of William Dawson to the principalship they also had encouragement from the chief executive of the university. The faculty of which Robert Palmer Howard was Dean made possible chairs for outstanding men, one of whom was William Osler who taught there from 1874 until 1884.

Schools in Upper Canada

As mentioned previously, Upper Canada opened a medical school at St. Thomas in September, 1824. This

(Continued on page 98)

**Information recently received from Dr. W. W. Francis of Montreal, states that, despite the lack of a charter, lectures in medicine were opened at McGill in July, 1822, and, on November 12, 1823, lectures in midwifery and the diseases of women and children were begun at the Montreal Medical Institution.*



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* *This motion picture has been approved by the Committee on Medical Motion Pictures of the American College of Surgeons.*

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Hospital Credit and Collections

Part II

IT IS most important in hospital policy that a definite time of discharge be established. Here, again, a co-operative understanding between patient, doctor, and hospital pays dividends. Patients and doctors should know that the proper time of discharge is during the regular business hours in order that the patient and his account may be given proper attention by the business office. The co-operation of the nursing service is not only desirable but essential in this regard. When a notice of discharge is received from the ward through the nurse or ward clerk, the accounting department should record all unposted charges for care by the day and post special services to the patient's ledger and prepare the patient's final account. It may be advisable to have a representative of the business office bring the account to the patient's room and arrange for settlement. Such a procedure is often followed with respect to patients occupying private rooms since it is convenient for the patient and ensures privacy in the event credit arrangements must be discussed. Ward patients are usually requested to report to the office before leaving and usually a nurse accompanies the patient to the office at the time of discharge. Here, also, the ward clerk can render valuable service.

In the event the patient is not able to pay in full at the time of discharge, it is desirable and important that this fact should be known and reported before the day of discharge. If proper follow-up is maintained, embarrassment can be avoided for both patient and office staff. No statement should ever be made that the patient cannot leave the hospital until the bill is paid —such a procedure is unlawful.

It is essential, however, that the account be arranged before the patient leaves and that private discussions involving personal matters be conducted in a private office. Such arrangements may be (a) payment in full at a future date; or (b) installment payments of a specific amount over a period of time.

Promissory Notes

It may be advisable to have the person responsible sign a note for the amount due. When a credit rating of a patient is questionable, it is a good idea to obtain a written guarantee from a relative or friend that the account will be paid. Be sure that such a guarantee meets the legal requirements in the event of possible court action. The acceptance of notes as payment has both advantages and disadvantages. A note properly signed is usually accepted by the court as evidence of the debt. A debtor might consider a note more binding than an open, unpaid account. The disadvantages are:

(a) Unless a demand note is received, the hospital is restricted in its collection efforts until due date;

(b) Acceptance of notes often results in the renewing of the note on due date with no attempt at reduction;

(c) Debtors often sign notes as a means of delaying payment, relieving themselves of any obligation prior to the due date. If it is generally known that notes are accepted, some patients may request the right of signing a note with the sole purpose of delaying payment;

(d) Some may interpret a note as a reflection on their integrity;

(e) The person responsible may use this arrangement rather than take the trouble to work out a reasonable plan for installment payments.

Care should be exercised to avoid accepting a promise to pay which those concerned know cannot be met. A debtor may become discouraged and make no effort to pay as a result. Installments and periods to pay should always be determined in view of existing circumstances. A special form of agreement may be used with a signed copy for both patient and hospital. A system of follow-up notices should be set up after arrangements for periodic payments.

Post-dated cheques are occasionally presented as a means of payment. While it is a criminal offence to issue cheques on an account when it is known that sufficient funds are not available at the time to cover it, this does not apply to a post-dated cheque. Do not credit a post-dated cheque to the patient's account until it is accepted by the bank.

After Discharge

The collection procedure followed after a patient has left hospital is usually determined by the financial arrangements made at the time of discharge. In many instances, the success of the effort will depend upon the follow-up system installed to remind the person in charge of collections that certain accounts require attention. It is the dream of every credit manager, certainly every hospital superintendent or administrator, to have all accounts paid on discharge or on the date arranged.

If, for any reason, a patient should leave hospital without making the customary arrangements for payment, it is reasonable to send an account the next day with a covering letter requesting payment of the account in full within the next few days. In the event of the death of the patient, special procedures are followed. A waiting period should be observed before sending the account to the family of the deceased and then it should be accompanied by a special letter.

The follow-up on collections may be through correspondence, telephone calls, telegrams, or by personal interviews. No hard and fast rule can be adopted. The circumstances in each case will determine the most effective method or combination of methods.

It is becoming more generally re-

(Continued on page 106)

George McQueen,
Officer Manager,
Hamilton General Hospital,
Hamilton, Ont.

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TABLETS—Each tablet is equivalent to 1 teaspoonful (5 cc.) of Oral Suspension Bicillin-Sulfas.

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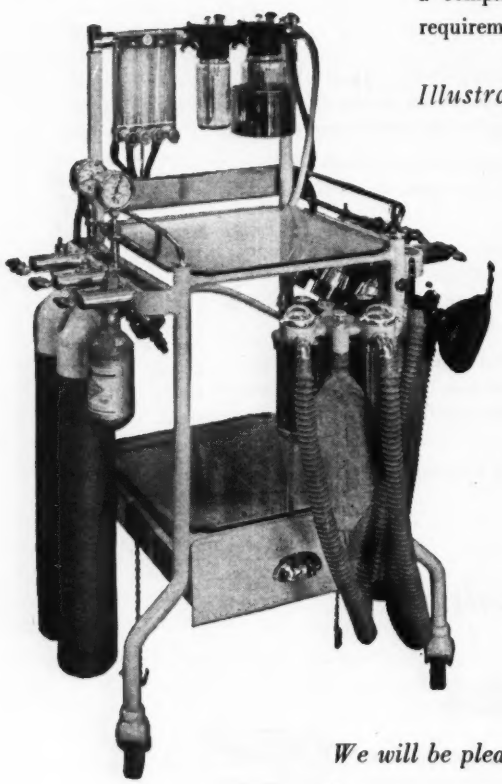

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Food and Its Service

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How Dietitians Can Help Diabetics

H. R. McAlister, M.B.,
Hamilton, Ont.

DIETITIANS have a great responsibility thrust upon them in their work with diabetic patients whose menus they plan and whose meals they prepare. Few doctors, myself included, possess the technical knowledge which dietitians have of foods and food values. It is seldom that a physician can dispense his own prescription of so many grams of protein, fat, and carbohydrates, into slices of bread, servings of meat, vegetables, and fruit. This is left to the dietitian, as well as the preparation of the menus and the necessary instructions to the patient as to diet. I have over the years, treated many patients with diabetes and it is on their behalf that I write. As dietitians, you see them only for the brief period while they are in hospital, while we doctors follow them through the years under actual living conditions, where they have to prepare their own meals, or select their diet from a restaurant menu. However, during this brief period of hospitalization, the diabetic receives from you his basic training in living a diabetic life and the realization of the important role that diet plays in his life. From his menu sheets, which should be on every tray, he learns the rudiments of diabetic diets, such as the fact that sugar, pies, cakes, and cream sauces are not permitted. He learns, too, the differences in various foods which he is permitted to have. The lessons he learns in hospital are not soon forgotten and must be adequate if he is to carry on efficiently outside.

Only a few years ago, there would have been great variance in the types of diet prescribed, from the very high fat with low carbohydrate, to the opposite of high carbohydrate with very low fat. Fortunately, these extreme differences have largely disappeared and the majority of the authorities are in closer agreement. Nearly everyone is now prescribing a diet higher in carbohydrate than formerly, protein as in the normal diet or slightly above, and fat in amounts to keep the patient's weight up or down, according to the ideal weight for his age and height. With the higher carbohydrate diet, the dietitian's task of planning a day's meal is easier and more satisfying to the patient.

The number of grams of protein, carbohydrate, and fat in the diet is almost invariably directed by the physician He counts on the dietitian, however, to see that its mineral content is sufficient and that there is no lack in the essential vitamins. You will notice that the protein content in the diet of growing children and pregnant diabetic women is kept at a high level.

We know now that food value tables are not as absolutely accurate as we once thought them. While we still speak of oranges as a 10 per cent fruit, we know that its carbohydrate content may vary from 6 per cent to 12 per cent or even more, depending on whether it was grown in Florida or California, whether it was fully ripe when picked, and at what season of the year it matured.

The protein and fat content of meat varies enormously, even of the same variety. I understand that the protein content of our Canadian wheat is lower this year than usual. All these things being true, our figures for the fat, carbohydrate, and protein content of any article of food are only approximations. Therefore, there is no place for decimals in the dietitians' work sheet.

Measurement by Grams

Measurement by grams is of great convenience to us; and the patient should be instructed so that he thinks of his articles of food in terms of grams rather than ounces. While in hospital his food is listed in grams but, certainly, when he goes home, domestic measures should be on his diet slip as well as the gram weights.

For years, I have not prescribed weighed diets for my adult patients. The approximations should be as simple as possible. In Hamilton, an ordinary slice of bread, cut ½" thick will weigh 30 grams or 1 ounce. This is the thickness of purchased sliced bread and, consequently, we prescribe our bread in multiples of 30 grams. We list our common fruits with their weight or domestic equivalent adjusted, so that one portion contains 10 grams of carbohydrate. For example, ½ small canteloupe (100 grams) which is a 10 per cent is equal to ½ small banana (50 grams) which is a 20 per cent, since they will both contain 10 grams of carbohydrate. Therefore, in this way, we can substitute a portion of fruit for ½-slice of bread. True, there may be a gram more of carbohydrate in the fruit but then there will be little more than a gram of protein in the bread to make up for this.

For some years, I have permitted my patients to use 5 per cent vegetables without measuring them and without estimating their carbohydrate content. I have had no greater difficulty in keeping them balanced than formerly when they, too, were measured.

With the 10 per cent vegetables more care should be taken and with the 20 per cent vegetables, extreme caution should be exercised. Nearly everyone knows that potatoes are high in carbohydrate but few of the public are aware that navy beans and corn are their exact equivalent. These 20 per cent vegetables are, however, lower in

An address presented at the dietetic section, Ontario Hospital Association convention, Toronto, Oct., 1952. The author is a specialist in diabetes at the Hamilton General Hospital.

"Sure, it will have a 'new look' outside— but it's really old-fashioned!"

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carbohydrate than bread which is 50 per cent and, therefore, are bulkier. Many patients are quite glad to be able to have an extra medium potato 2½" x 1½" in place of ½-slice of bread.

The proteins of the average diabetic diet do not present much of a problem. If you figure your meat, fish, or chicken in 30 gram multiples, a sufficiently accurate substitution for all practical purposes will be: 1 portion of meat equals 1 egg equals 1 cube of cheese 1" x 1" x 1". Therefore, if 90 grams of meat are allowed at dinner, if the diabetic wished to take only 60 grams, he may have a 1" cube of cheese. I seldom find my patients want more protein than I prescribe, rarely less than 60 grams or more than 100 grams and, therefore, I permit them considerable leeway in this respect.

With some patients the question of fat in the diet is a problem. If they are overweight, this must be severely restricted so that they may reduce. We have found that a convenient method of calculating butter is to cut an ordinary pound in slices ¼" thick and divide the slice in four. Each of these will weight approximately 10 grams. When patients gain weight and we suspect that they are over-estimating their butter, we advise them to measure the day's ration in the morning, put it aside, using it as they please at each meal. Cream should be forbidden in the diets of these patients, as they will invariably take more than they should. Pork and pork products should also be forbidden as they are too high in fat. Where the patient's weight is not a problem and the doctor has ordered a diet of 80 or 90 grams of fat, the patient's wish should be taken into consideration as to whether cream or butter is desired. One square of butter may be substituted for 3 tablespoons of 18 per cent cream.

Spacing of Meals

The spacing of meals is important. They should not be crowded too closely together. A diabetic often handles more food if his meals are properly spaced. Unfortunately, due to conditions beyond their control, most hospitals offend in this respect and there is too long an interval between the evening meal and breakfast and too short a period between noon dinner and the evening meal. When they go home, the majority of patients will have their hot, heavier meal at night at 6 p.m. or 6.30 p.m., instead of the cold meal at 4 or 4.30 p.m. as at the hospital.

With the different kinds of insulin now in use, it is important for the dietitian to know just what kind of insulin the patient is taking in order to distribute the food most advantageously. Probably most patients are on one dose of protamine insulin and one dose of regular insulin, administered separately before breakfast. Such patients usually do well with the three meals approximately even in their food content and a bed-time lunch of a glass of milk with soda crackers. I believe that this evening snack is important because it prevents too low a blood sugar count past midnight and early morning insulin reactions. At times, if the patient desires a little more nourishment than this and if the diet is sufficiently high, a small sandwich with the milk may be allowed. The regular insulin taken in the morning allows this patient a little heavier breakfast than can be given when the patient is using protamine insulin alone.

With the N.P.H. insulin or with globulin insulin, breakfast must be reduced for these types are slower in their initial action than regular insulin. This reduction from the breakfast should be given in the mid-afternoon, and their bed-time snack is never heavy. Such patients handle their noon and evening meals better than their breakfast. With adults, slight undernourishment is still important, especially with those who are markedly overweight.

Children, I believe, should have three meals a day, plus a snack at morning recess, a snack after school and a bed-time glass of milk or its equivalent. This will present no problem now that all diabetic children are receiving more generous diets than formerly. Undernourishment plays no part today in their treatment. As the children grow and advance into higher grades at school, we can sometimes omit the mid-morning nourishment now that we have N.P.H. insulin. However, the afternoon snack should never be omitted.

A Visit Can Be a Revelation

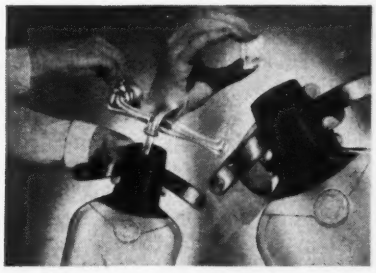
The dietitian should see the patient in the hospital frequently so that, as much as possible, the individual's wishes are respected. It makes a great difference to the person who abhors beets to be fed them three or four times a week. Make sure that Mrs. "B" has that vegetable omitted from her tray; surely she might have carrots or turnips which she does like. Mrs. MacDonald likes oatmeal porridge and will relish it every morning in the week; therefore, she will be resentful if she gets only shredded wheat or cornflakes. Make it a point to go to the ward and actually see what the patient gets on his tray. You will be surprised how often the maids have put on the sugar bowl or that the 75 gram apple (small) has grown to the size of a small grapefruit between the time it has left the kitchen and its arrival on the ward. If you visit the patient you will sometimes see that the lady with the good Irish name of O'Reilly is really Jewish. True, she claims not be Orthodox and may eat her bacon for breakfast but, if you follow her to her home, you will find that instinctively she observes a measure of Orthodoxy. You should know that, aside from eating pork, it is against Jewish teaching to have meat and dairy products at the same meal. Arrange her diet so that butter and milk are omitted when she has meat. She will be grateful to you. Our elderly Chinaman must have his rice and will eat it when he goes home. Therefore, why not let him have it in hospital with his insulin adjusted to take care of it. The same thing applies to the Italian patient. Spaghetti is almost a must for him. Take the trouble to calculate it in his diet, omitting the potato and reducing the amount of his bread. You will have no trouble with him in the matter of eating 5 per cent vegetables but he will insist on a little olive oil. When he understands that olive oil and butter are inter-changeable you will find him more co-operative. The scales will usually tell the story for if he is gaining weight again, it is probably due to the olive oil.

How about saccharine and sacaryl? There is a place for artificial sweetening in foods which are naturally sour, such as rhubarb. Save the sweetener for these things. Saccharine has a rather bitter flavour when cooked, while the newer sweetener, sacaryl, is not bitter when cooked and is, therefore, probably more satisfactory. Whether one adds sugar to tea or coffee is purely a matter of habit. For the person who likes his coffee clear, sugar will spoil its taste. It is poor

(Concluded on page 110)

3 Reasons for STOPPERLESS

ECONOMY—If you were to buy a cheap hot water bottle and a cheap ice bag, the combined cost of these two items would exceed that of the Stopperless Hot Water Bottle and Ice Bag Combination. That's Reason No. 1.



UTILITY—Unique neck construction accepts hot or cold water *and* ice cubes. AND, it will not leak. We threw it off the top of a 7-story building, filled with hot water—it didn't lose a drop. That's Reason No. 2.

LONG LIFE—No faulty or missing parts can disable Stopperless. There are no washers, no stopples, no chains, no threads. No leaks, no worries, no complaints. Satisfaction assured. That's Reason No. 3.

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The Saskatchewan experience—

Protecting Nurses Against Tuberculosis

R. G. Ferguson, M.D.*
Regina, Sask.

IN THIS GENERATION, infection from tuberculosis has steadily decreased in all parts of Canada, as a result of the rapid fall in deaths from this disease and consequent decline in spreading foci. Thus the great majority of young girls, around the age of twenty, who enter hospitals for training or sanatoria for employment, have not been infected with the *tubercle bacillus* and have not acquired resistance to tuberculosis. These more susceptible young women, many of whom in the natural course of their duties will be unavoidably exposed to tuberculosis, require protection if they are not to suffer excessively from this disease.

Adequate protection for these employees is the responsibility of all hospitals, if such institutions are to be considered desirable places to work. The solution of the problem reduces the difficulty of maintaining adequate and efficient staff in an era of full employment when young women have increasing choice of employment and health is appreciated as a precious asset.

It must be recognized that nurses caring for the sick are unavoidably exposed to disease. This, however, does not deter them in the least if they are interested in their work and can be assured that protection is afforded against disease.

Provisions for Protection

Where increasing resistance and reduction of infection are major factors of prevention in a community program, a problem requiring special consideration is the protection of that group in the community who are destined to have more than average exposure to tuberculosis infection—that group who are known to be, to a large degree, unavoidably exposed. In order to make the problem definite, let us review briefly, provisions made for the protection of sanatorium and hospital ward employees.

In the 1930's, in many places, particularly in the United States, Canada, Australia, and New Zealand, staff, closely associated with bed-side care and with cleaning in sanatoria and hospitals, were breaking down in increasing numbers, as were also nurses-in-training in general hospitals, and nurses and attendants in mental hospitals. The sanatoria and hospitals became worried over this condition and checked up on pre-disposing causes of breakdown. Better living conditions, including many new nurses' homes and the services of dietitians, were provided. Better instruction in infectious techniques was instituted.

The value of sanitary technique in protection against infection has been demonstrated in both acute infectious hospitals and sanatoria. Considering the human difficulties during the period of apprenticeship, the protection conferred by sanitary habits is, in a practical way, limited. This fact is best illustrated by the cases of nurses-in-training who may be considered amateurs in the practice of sanitary technique. Protection by this method is acquired after long and intensive practice, is maintained at the price of eternal vigilance, and is subject to human error. Notwithstanding these efforts to improve non-specific protection, the problem remained. If sanitary technique alone afforded sufficient protection, prophylactic vaccination against small pox would not be insisted upon for nurses nor would toxoid prophylaxis against diptheria be a protective measure in infectious hospitals.

In Saskatchewan, morbidity from tuberculosis has steadily fallen among the general population since 1930 but, prior to 1939, among sanatoria and hospital employees, morbidity had not fallen. New active cases of tuberculosis discovered from 1930 to 1938 in Saskatchewan are shown in Table 1.

On June 30, 1939, under treatment in Saskatchewan were 17 graduate nurses, 13 nurses-in-training, and 12 other hospital attendants — constituting 5.3 per cent of the 780 patients under treatment.

This study shows that during the period 1930-1935, the average incidence of admissions among nurses-in-training was 1.14 per cent per annum, and for the years 1936-1938 inclusive 1.6 per cent per annum. The average for the nine-year period 1930-1938 was 1.44 per cent per annum. This incidence was nearly ten times that found among young adult Normal School pupils examined each year in a similar age group (0.15 per cent) and nearly ten times that in the general female population in Saskatchewan in the age group 20-24 years known to have fallen sick in 1938 (0.152 per cent).

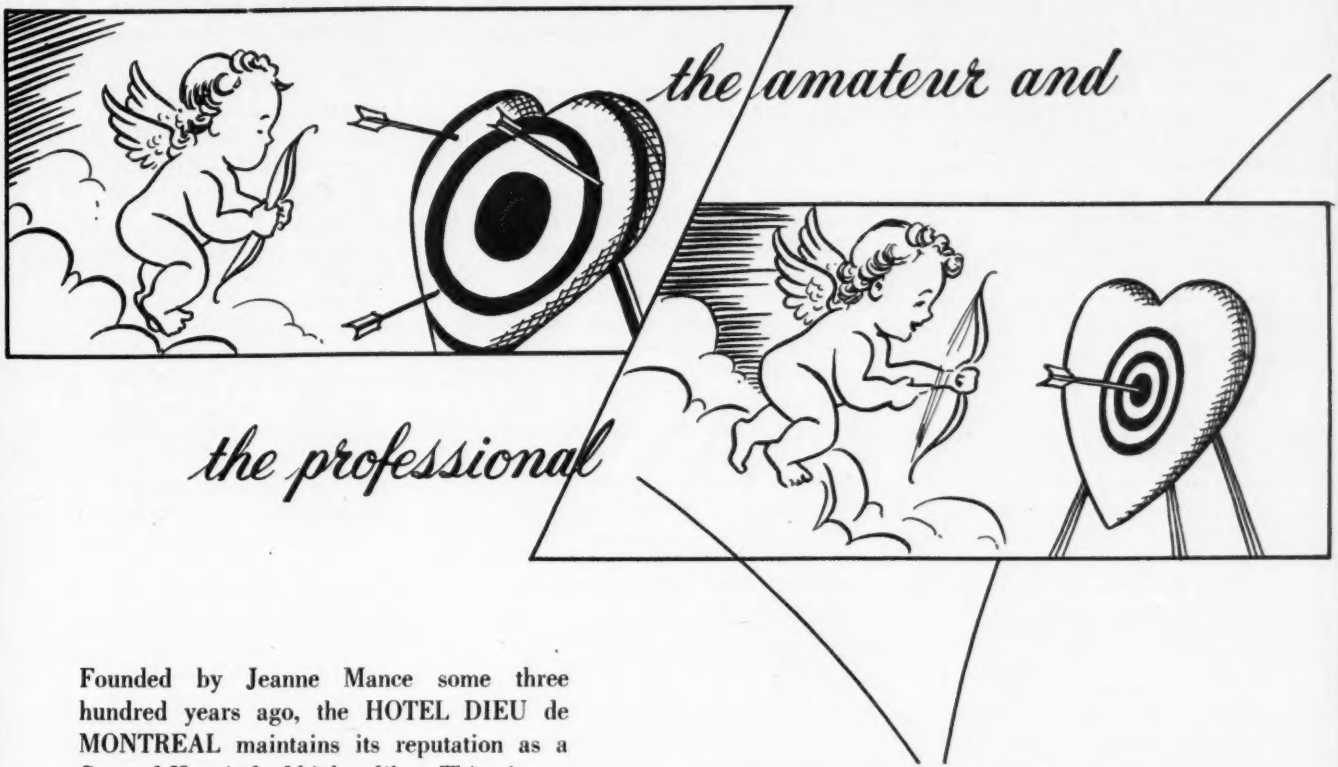
In 1930, a further effort was made to protect the staff against serious disease and a routine examination by

TABLE I

Year	Graduate Nurses	Student Nurses	Assistant Nurses	Total
1930	12	10	2	24
1931	10	14	2	26
1932	10	12	0	22
1933	12	9	2	23
1934	7	10	0	17
1935	10	7	0	17
1936	10	10	3	23
1937	5	10	5	20
1938	12	11	8	31
Total	88	93	22	203

Dr. Ferguson was formerly director of medical services and general superintendent, Saskatchewan Anti-Tuberculosis League.

THERE'S A DIFFERENCE BETWEEN



Founded by Jeanne Mance some three hundred years ago, the HOTEL DIEU de MONTREAL maintains its reputation as a General Hospital of high calibre. This picture shows the new wing where all hospital services are concentrated. One complete floor has been set aside for laboratory equipment and services; another for Radiology; a third for the ten most modern Operation Rooms. The last three floors are provided for the comfort of all post-operative cases.

Again, ART WOODWORK engineers were entrusted not only with the fabrication and installation of all of the laboratories, but were given the task of planning the complete installation.

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x-ray, upon employment, was established, followed by periodic x-ray examination. Still a high morbidity persisted. In 1934, tuberculin testing of all new employees (and of negative reactors at intervals thereafter) was established. In 1939, it became possible to make a preliminary analysis of the information gained by a study of tuberculin, x-ray, and physical condition in three sanatoria. This study revealed three outstanding facts.

First, it was found that in the decade an increasing proportion of the staff had been employed year after year with negative tuberculin reactions, the proportion increasing from 31.7 per cent in 1934 to 60.4 per cent in 1938.

Secondly, it was found that staff with negative tuberculins who were unavoidably exposed to tuberculosis soon became positive; of those groups having more or less contact with patients, 60 per cent became positive within the first year of service and very few went beyond two years.

Thirdly, it was observed that a higher proportion of the breakdowns occurred among employees with a negative tuberculin reaction, compared with the incidence among those with a positive reaction. During the five-year period, January, 1934, to December, 31, 1938, among 359 exposed persons, having a positive tuberculin on employment, 1.1 per cent developed lesions demonstrable by x-ray—an incidence of 0.22 per cent per year. This incidence was slightly higher than that suggested by the number of admissions for treatment among young adults in the age group 20-24 in the general public (0.152 per cent) in the same province. This incidence was very much lower than that found among young adults on the same staff who were negative to tuberculin, on employment. During the same period, among 306 employees found negative to tuberculin on employment, 2.026 per cent per annum developed lesions demonstrable by x-ray. Not all of those who developed lesions required treatment. Small lesions cleared up while employees continued to work, under observation. You may feel that these transitory lesions were of no practical importance. Nevertheless, after eliminating lesions which did not require treatment among those 306 employees who were negative to tuberculin, 1.04 per cent per annum required sanatorium treatment. This incidence was 4.7 times greater than the incidence requiring treatment among those employed with a positive reaction.

It would appear from these observations that favourable living and working conditions in hospitals and sanatoria, combined with preventive technique as practised, gave reasonable protection to persons who had acquired resistance afforded by precious infection, without a parenchymatous lung lesion. However, these conditions did not provide adequate protection for negative-to-tuberculin employees in the same environment.

Sanitary technique, if perfect, would eliminate infection but, inasmuch as it is subject to human error, it may at least be expected to avoid infection in some cases and to reduce infection in others. It protects some of the fortunate and very painstaking ones; however, in most cases it merely postpones the evil day when accident or laxity will let down the bars for infection.

In September, 1938, it was decided to offer prophylactic vaccination with B.C.G. to all negative-to-tuberculin nurses in the eight large general hospitals in Saskatchewan and to all negative-to-tuberculin employees in the three sanatoria of the Saskatchewan Anti-Tuberculosis League.

Table Number II compares the experience in general hospitals and in sanatoria during the period 1934 to 1947. These figures include any cases developed after leaving hospitals up to November, 1948.

Thus vaccination of negatives reduced the incidence of tuberculosis cases in the hospital group to its fifth and in the sanatoria group to its sixth.

Since July, 1945, the employees of the League have been protected by sickness and accident disability insurance, including tuberculosis, with standard individual policies at minimum standard rates. The experience of the insurance company has been satisfactory.

The serious situation that had been developing with regard to excessive incidence of tuberculosis among nurses and sanatoria employees who did not react to tuberculin upon entering the environment, during the period 1930 to 1938, has not been present since vaccination of negative reactors began in September, 1938. The nursing schools and the League in Saskatchewan no longer worry about excessive tuberculosis developing among the negatively reacting staff.

Since this study was made vaccination has been introduced in many large hospitals and most sanatoria from British Columbia to Newfoundland and, wherever practised, the results have been to eliminate excessive tuberculosis among nurses who are negative to tuberculin.

TABLE II

Hosp. Nurses-in-Training	No. of Persons	Tbc. Cases	% Tbc.
Total vaccinated observed	2,223	18	0.809
Total negatives not vaccinated	1,368	55	4.02
Ratio of cases among vaccinated to negatives not vaccinated —0.809:4.02=1:4.97			
Saskatchewan Sanatoria			
Total vaccinated	1,223	21	1.8
Total negatives not vaccinated	247	32	11.67
Ratio of cases among vaccinated to negatives not vaccinated 1.8:11.67=1:6.6			

Maritime Hospital Accountants Organize New Chapter

At the hospital accounting institute, sponsored by the Maritime Hospital Association, from November 25-27th, Moncton, N.B., (see Jan. p. 52) a Maritime chapter of the American Association of Hospital Accountants was organized. Officers pro-tem are S. J. Bradshaw, Antigonish, N.S., president, and W. J. Tudor, New Glasgow, secretary-treasurer.

Aims and objectives of the chapter are: (1) to bring about closer co-operation among hospital accountants in order to promote uniformity and efficiency in hospital accounting; (2) to co-operate with hospitals and their associations in matters pertaining to hospital accounting and statistics; (3) to encourage and assist members to increase their knowledge of hospital accounting, including cost accounting: (4) to provide a medium for the interchange of ideas and dissemination of material relative to hospital accounting; and (5) to encourage and assist in the holding of meetings and conferences on hospital accounting.

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◂ Notes About People ▸

John C. Lee New Superintendent Swift Current Union Hospital

John C. Lee, formerly a hospital administrative consultant, division of hospital administration and standards, Department of Public Health, Regina, Sask., has accepted the position of superintendent at the new Swift Current Union Hospital, Swift Current, Sask. He succeeds E. V. Wahn who has become business administrator at the University of Saskatchewan Hospital in Saskatoon.

Mr. Lee was born in London, Ont., where he received his early education. After graduating from the Ontario College of Pharmacy, Toronto, in 1939, he enlisted in the Canadian Army, serving in the artillery corps and later in the R.C.A.M.C. In 1946 he enrolled in the University of Saskatchewan, graduating in June, 1948, with the degree of Bachelor of Science in pharmacy. He was appointed an instructor on the faculty of pharmacy at the university for the academic year, 1948-49. In 1949, he enrolled in the post-graduate course in hospital administration, University of Toronto and, on completion of his administrative residency at the Hamilton General Hospital, Mr. Lee was appointed to his post with the Saskatchewan government. During his service with the government, he was "on loan" to the Canadian Hospital Council for a few months in 1952, in order to assist in lesson preparation for the C.H.C. extension course in hospital administration.

Mr. Lee commenced his new duties in January.

John C. Lee

* * * *

Harold Orr

Dr. Harold Orr, president of the Canadian Medical Association, died in Toronto on Dec. 26th, on his way to his home in Victoria, B.C. Dr. Orr had been attending meetings of the World Medical Association in Athens, Greece, last October, when he suffered his first coronary thrombosis. From Athens, he had travelled to London, England, where he spent four weeks at St. Thomas's Hospital and from there he sailed to New York where he was again hospitalized before coming to Toronto.

A graduate of the University of Toronto, class of 1911, Dr. Orr was the professor of dermatology at the University of Alberta Medical School. Previously he had practised medicine in Medicine Hat and Edmonton, Alberta.

* * * *

John J. Healy

The Rt. Rev. Msgr. John J. Healy, former president of the Catholic Hospital Association, died in Little Rock, Arkansas, on December 6th, after an illness of many months.

For the past 16 years, Monsignor Healy distinguished himself in local, state, and national hospital affairs. When elected president of the Catholic Hospital Association in 1951, he was a member of the Board of Trustees of the American Hospital Association, which he also served as vice-president. He was a member of the Joint Commission on Accreditation of Hospitals, representing the A.H.A.; and was a charter member of the House of Delegates of the American Medical Association, representing Arkansas from 1938 to 1940. An outstanding leader in hospital work in Arkansas, Msgr. Healy had served as president of the Arkansas Hospital Association and as a member of its board of trustees, as well as holding other positions in the health field.

* * * *

E. V. Wahn Accepts Position at University of Saskatchewan Hospital

E. V. Wahn, who had been superintendent of the Swift Current Union Hospital, Swift Current, Sask., since 1951, has been appointed business administrator at the new University of Saskatchewan Hospital, Saskatoon.

Mr. Wahn, a native of Saskatchewan, received his early education at Swift Current and Yorkton. Afterwards, he studied economics at the University of Saskatchewan and at Queen's University, Kingston, Ont. He is also a graduate of the course in hospital administration at the University of Toronto, Toronto, Ont.

E. V. Wahn

Mr. Wahn had been secretary of the Saskatchewan Health Services Planning Commission from 1946 to 1948 and had served as a hospital administrative consultant with the Saskatchewan department of health in 1950.

* * * *

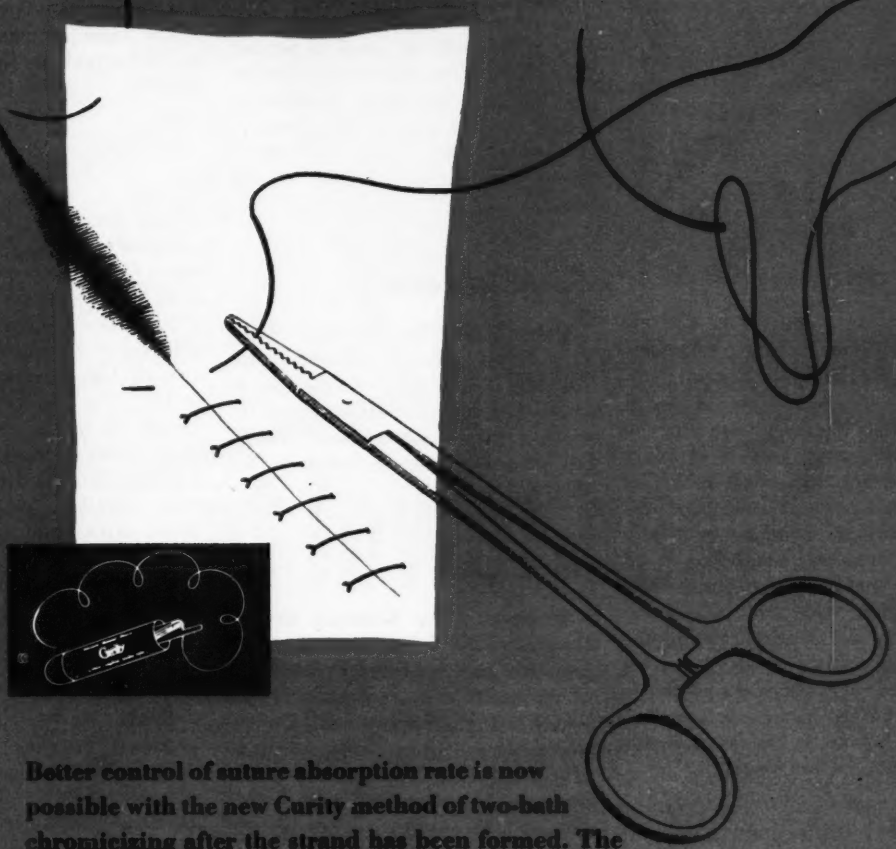
Norman F. Mutter, Administrator Archer Memorial Hospital

Norman F. Mutter has accepted the position of administrator at the Archer Memorial Hospital, Lamont, Alta. He

(Continued on page 104)

Curity chromic sutures

are chromicized with two baths for dependable absorption



Better control of suture absorption rate is now possible with the new Curity method of two-bath chromicizing after the strand has been formed. The first bath *does not "tan"* but permeates the strand. The solution used in the second bath combines with the molecules of the first, within the strand, achieving total, even chromicization from rim to center. As a result absorption is similarly uniform. By this method the plies are bonded by their natural mucin.

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Provincial Notes

British Columbia

PORT ALBERNI. At the end of November, the new $1,000,000 West Coast General Hospital was officially opened. Built to replace a 40-year-old institution, the new hospital has four completed floors and a fifth with roughed-in services for future expansion. Present bed capacity is 102, with space in the fifth storey for 48 additional beds.

* * * * *

POWELL RIVER. A new contract between the Powell River General Hospital and its employees calls for a three per cent wage boost but, together with a large number of salary reclassifications, will result in an increase of five per cent in the total payroll. Additional benefits were also granted employees, one being a 40-hour week and in some departments a five-day week. One additional statutory holiday was granted bringing the total in the year up to 11. A cost-of-living bonus of $5.85 was included in wages before the increase was applied. Sick leave was set at 1½ days a month, accumulative for two years.

* * * * *

WHITE ROCK. A scale model of White Rock's proposed $200,000 hospital has been completed by the architect, Robert C. Bennet. The 37-bed, T-shaped building will have windows extending to the ceiling. Administrative offices are located in the centre of the two arms; the maternity section, with kitchen and storage facilities in the basement, is housed in one wing and the operating rooms in the other. Patients will be accommodated in the wing extending perpendicularly from the centre section. Excavation of the hospital site has been completed already.

Alberta

CALGARY. A $10,000 chest x-ray unit has been installed in the new wing of the Calgary General Hospital. The unit, which will be similar to one placed in the Holy Cross Hospital by the Alberta Tuberculosis Association during the past year, will be used to give routine chest x-rays at a cost of $1 to all patients admitted to the hospital.

Saskatchewan

MOOSE JAW. The old wing of the Moose Jaw General Hospital was closed on January 1st of this year in accordance with instructions from the provincial fire commissioner. The 58-bed wing had been in operation for 46 years.

Manitoba

WINNIPEG. The Winnipeg General Hospital's $5,000,000 expansion program has been approved by the board of governors and construction is expected to begin this summer. A seven-storey wing, west of the admitting office, will be included in the building program. Another two-storey addition will be constructed between the nurses' residence and the Jubilee block. It will contain personnel offices, a diet and general kitchen, and quarters for stores in the basement. On the first floor there will be a nurses' and personnel dining room to seat 350. To make room for this building, ward block A and B, an old two-storey structure to the south of the main building, will be torn down.

It is expected that a campaign will be launched in May to raise $2,000,000 by public subscription. Another source of revenue will be a bequest of more than $1,000,000 which was left to the hospital by the late Mrs. Frank Shea. Moody and Moore, architects, Winnipeg, have drawn up the plans.

Ontario

BRANTFORD. Proposed plans are being drawn up for the renovation and extension of the Brantford General Hospital. The extension would provide space for 186 additional beds and 72 beds which could be made available as the need arises. Plans call for the construction of a seven-storey building, to contain additional beds and new service facilities, and a boiler plant and power house. It is expected that the new building and renovations to the older sections of the present hospital would cost approximately $2,874,000.

* * * * *

FORT FRANCES. The new $700,000 addition to the LaVerendrye Hospital was officially opened in December. Built at a cost of approximately $559,332, the new wing provides accommodation for 60 patients and raises the over-all bed capacity of the hospital to 100. The laundry and cafeteria are located in the basement of the four-storey wing; laboratories, emergency department, treatment rooms, and three operating rooms, on the first floor; private and semi-private wards, on the second floor; and the maternity department is on the third floor.

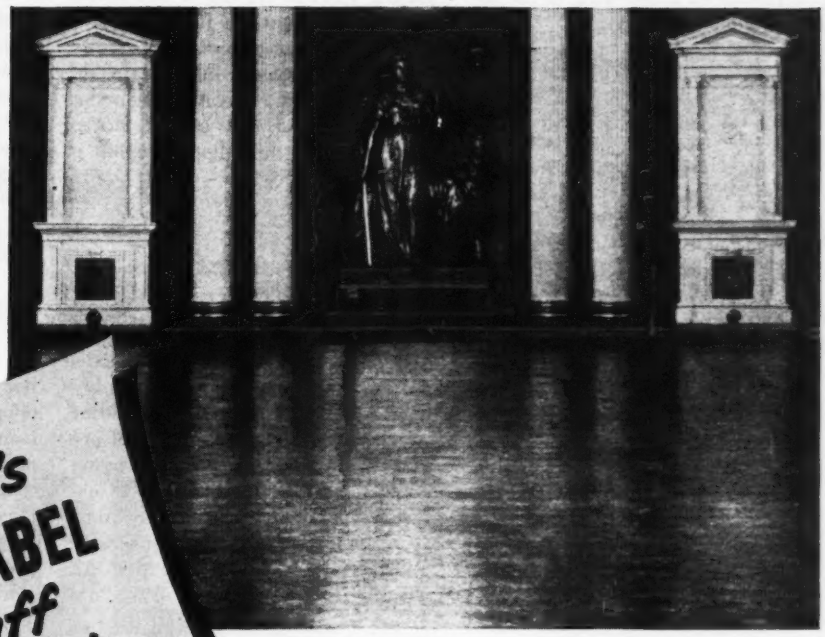
* * * * *

GALT. A campaign, which was launched to raise a minimum of $500,000 for the new South Waterloo Memorial Hospital, closed at the end of 1952 with a total of $775,320.50. Donations were still being submitted after the campaign closed and it is anticipated that the fund might reach $785,000.

* * * * *

HANOVER. Renovations to the Hanover Memorial Hospital have been completed and the hospital has been reopened to receive patients. Alterations were necessary after fire gutted the third floor of the building, in June of the past year. The third floor of the building has been removed and a flat roof has been built over the second floor. Plans are under way for the

From Johnson's Wax



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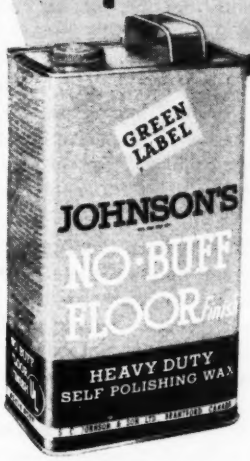

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construction of a new wing to the present building this spring.

* * * *

KITCHENER. The former Kitchener-Waterloo Hospital, which has been converted into a unit for long-term patients, has been officially named the Kathleen Scott Pavilion of the Kitchener-Waterloo Hospital. The name was chosen to honour the memory of the late Kathleen Scott who had been superintendent at the Kitchener hospital.

* * * *

MOUNT FOREST. A new $40,000 nurses' residence for the Louise Marshall Hospital has been officially opened. The two-storey building has accommodation for 13 nurses and also contains an apartment for the hospital superintendent.

* * * *

SOUTHAMPTON. An auxiliary power unit has been installed at the Saugeen Memorial Hospital. The gasoline-operated generator provides a total of 1,500 watts and will permit emergency lights for the entrance, hallways, and kitchen, as well as an emergency lighting system for the operating room and delivery room. Outlets for the use of the oxygen tents will also be installed so that in the event of a power failure they may be kept in operation.

* * * *

STRATFORD. Room rates have been increased by 50 cents per day at the Stratford General Hospital, as of January 1st. The new rates, applicable to adult patient rooms only, will bring in an annual income of approximately $16,000 for the hospital. The boost will bring rates for public wards to $6.50; semi-private $8.50; and private rooms from $10.50 to $12.50.

Quebec

SHERBROOKE. A campaign to raise $100,000 for the Sherbrooke Hospital will be held next month. Loss of patient revenue during a five-month period, when the third floor had to be closed because of a shortage of nurses, resulted in a sharp increase in the hospital's deficit. Recently the nursing staff was augmented by six British nurses and the third floor is again in operation.

New Brunswick

CAMPBELLTON. Satisfactory progress is being made in the construction of the new Campbellton mental hospital. A central services building, which is nearing completion, will provide all facilities for heating, power, laundry, and workshops. It will also house a temporary kitchen and dining room and temporary administration quarters adequate for the first 225 patients and the staff. Work is now under way on the construction of accommodations for 120 industrial type patients (one-half male and one-half female); 90 disturbed type patients; and eight receiving and observation beds; and seven medical and surgical beds. The buildings are planned to provide adequate sleeping space and an extensive area for class rooms, assembly rooms, occupational therapy facilities, and central bath units.

* * * *

SAINT JOHN. Authorization has been granted by the municipal council for the Saint John General Hospital's board of commissioners to proceed with plans for the construction of a 300-bed addition to the hospital. Estimated cost of the proposed expansion plans is $4,000,000 and it is expected that the additions will take about three years to complete.

Nova Scotia

ANNAPOLIS ROYAL. The new extension to the Annapolis General Hospital, built at a cost of more than $7,000, has been completed. Constructed on the west side of the original hospital building, which was opened in 1939, the new two-storey addition has been built to the same specifications, with allowances for further expansion. Increased storage space is provided in the basement portion of the new addition. The first floor contains a children's ward and diet kitchen, both of which are now fully equipped and in operation. The second floor provides bedrooms for the nursing staff. The storage and utility room in the basement of the older building has been converted into a sitting room for the domestic staff. Improvements to the heating system have also been effected.

* * * *

TATAMAGOUCHE. The Lillian Fraser Red Cross Outpost Hospital has been re-opened after being closed for a four-month period during which time a new wing was added and many renovations made in the original building. Located in the new addition are a nursery and children's ward, private and semi-private rooms, and four-bed wards. The basement contains a kitchen with an adjoining dining room for the nurses.

Roving Disease Detectives

Roving disease detectives of the Public Health Service, of the Federal Security Agency of the United States government, assisted state and local health departments in investigating and controlling more than 200 epidemics and three flood disasters during 1952, according to a recent announcement by the Surgeon General, Leonard A. Scheele.

The total was ten times greater than the average number of epidemic and disaster aid calls answered in recent previous years. Surgeon General Scheele explained that the increase was due to the fact that 1952 was the first full year of operation of the Epidemic Intelligence Service, a mobile corps of 32 epidemiologists, or epidemic trouble-shooters, attached to the Service's Communicable Disease Center at Atlanta, Georgia.

The Epidemic Intelligence Service is a part of the Communicable Disease Center's Epidemiology Branch, headed by Dr. Alexander D. Langmuir of Atlanta. When not quelling epidemics the 32 EIS medical officers are assigned to state or local health departments, schools of medicine or public health or other research laboratories stategically located in 16 states from coast to coast. At those posts they carry on continuing epidemiological investigations.

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Book Reviews

THE ADMINISTRATIVE MANUAL OF ST. MARY'S HOSPITAL, ROCHESTER, N.Y. Prepared by the administrator, in co-operation with the staff. Pp. 610. Illustrated. Price, soft cover edition, $6.00; hard cover edition, $8.00. Published by the Catholic Hospital Association of the United States and Canada, 1438 South Grand Blvd., St. Louis 4, Mo.

Sister Inez, D.C., administrator of St. Mary's Hospital, Rochester, New York, with the assistance of her administrative staff, has formulated a manual that is a monument to thoroughness and complete coverage of a given topic. Over six hundred pages in length, the manual deals with every aspect in the administration of the hospital, combining much of the theory found in standard texts with actual practical application on a local level.

Perhaps its greatest weakness also lies in its completeness and, therefore, large size. Procedures and policies are constantly changing and a guiding manual, to be efficient, must be up to date. To offset this difficulty, the manual has been prepared in loose leaf form, bound with screw fasteners which are fixed within the hard cover or soft cover binding. Thus, individual sheets or sections may be removed for revision and replacement. However, with a large volume, such as this, the task of maintenance will remain sizeable.

There is no question that setting down hospital policy in writing is advantageous. St. Mary's Hospital is provided now with a complete reference manual — valuable to any staff member but particularly so to directors and department heads. The value is further enhanced as it provides a comprehensive guide to new staff members and will be of special use to new administrative staff.

The Catholic Hospital Association of the United States and Canada in publishing the manual has provided a guide for other hospitals to follow. It offers a complete outline for the preparation of administrative manuals for other local situations, whether as complete or abbreviated versions.—*A. L. Swanson, M.D.*

PORTRAIT OF A HOSPITAL. To Commemorate the Bi-Centenary of the Royal Infirmary, Manchester. By William Brockbank. Illustrated. Pp. 213. Price, $5.00. Published by William Heinemann Ltd., Toronto, Melbourne, London, and Cape Town. Distributed by British Book Service (Canada) Ltd., Toronto.

A portrait, and a well drawn one, is this book commemorating the bi-centenary of the Royal Infirmary, Manchester, England. On July 27th, 1752, the "Publick Infirmary at Manchester" opened its doors and its growth has been chronicled in the minute books and annual reports which run in unbroken sequence from that day. The author has used these sources to good advantage. Some of the episodes related in the early days of the hospital are amusing to twentieth century eyes; and most of the incidents show the changing social structure, the reforms, and the progress in medicine and science. We learn about the hospital's absconding secretary who made off with £500 and was apprehended before he could sail for far distant shores; how the hospital was grossly misrepresented during the Peterloo riots; how the hospital coped with nursing problems back in the 1800's; when the first antiseptic techniques were used; how the new hospital, long envisioned, finally opened in 1908; and how medical specialization affected the hospital set-up. Although hit by bombs on two occasions during World War II, the hospital continued to serve and emerged from the war, battered and battle-scarred but ready to go ahead with rehabilitation.

The style of this book is interesting and illustrations vary from old prints of objects as long-vanished as a ducking stool to numerous drawings and photographs depicting the changing face of the hospital. The net result is a pleasing portrait of a hospital, renowned both as a treatment centre and as a teaching school.

* * * * *

"It's Your Hospital and Your Life!"

"It's Your Hospital and Your Life!" is a Public Affairs Pamphlet, Number 187, written by *New York Times* reporter, Lucy Freeman. In simple but catchy words, Miss Freeman has drawn, for the public, a picture of the modern hospital, showing its proper function and place in community life. She defines the word, "hospital", shows very briefly how hospitals developed, discusses what makes a good hospital, how it is financed, how it plans for the future, and how it advances with medical progress.

Expressing many ideas in a few words, "It's Your Hospital and Your Life!" contains accurate information, expressed in a style which should be very effective in interpreting the hospital to its community. This pamphlet can be obtained for 25 cents, from Public Affairs Pamphlets, 22 East 38th Street, New York 16, N.Y.

* * * * *

Births, Marriages, and Deaths From a World-Wide Viewpoint

The world's weddings, the world's babies, and the world's growing population are among subjects covered in the 700-page volume, *Vital Statistics and Causes of Death*, published by the World Health Organization, in Geneva. This volume is compiled on the basis of information supplied by national and municipal administrations.

At the end of World War II, the figures reveal that marriage rates throughout a great part of the world increased sharply as well as birth rates. Always in the period immediately following wars there are more boys born than girls and World War II was no exception. Reproduction rates supplementing the birth-rate figures show that the population is again tending to increase, especially in countries where a decline seemed to have set in before the war. In the majority of countries, death rates have been lower since before the war, in spite of the increased proportion of middle-aged and old people in the population.

As an adjunct to *Vital Statistics and Causes of Death*, a recent monthly edition of WHO's *Epidemiology and Vital Statistics Report* reveals that, compared with 1950, birth rates have fallen in most European countries, especially in Italy, while there has been

(Concluded on page 114)

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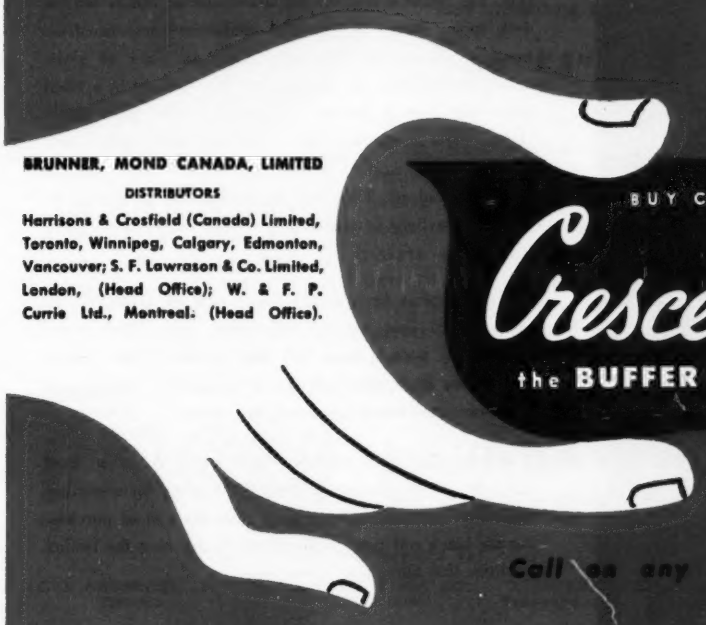

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Better Hospital Administration

(Continued from page 40)

of Hospital Administrators undertook a three-year curriculum study, financed by a grant from the W. K. Kellogg Foundation. (This study was part of a post-war project started by the W. K. Kellogg Foundation to further a long-range objective of providing trained administrators in sufficient numbers to meet the needs of the hospitals and related health services in the United States and Canada.) Between the year 1945 and the present time, 11 more schools for the training of hospital administrators were opened in quick succession, several of them receiving financial support from the W. K. Kellogg Foundation. Among these is our own post-graduate school at the University of Toronto and the graduate school of St. Louis University, the latter offering a course designed primarily for directors of Catholic hospitals.

Among all these programs there is a similarity in the fundamentals taught. Therefore, in order to promote the common interest of furthering education in the hospital field and, at the same time, to maintain a high standard of instruction, a number of these programs formed an association known as the Association of University Programs in Hospital Administration (A.U.P.-H.A.). This association works closely with the American College of Hospital Administrators and with the W. K. Kellog Foundation and other bodies interested in hospital administration. Within the past year, the association has undertaken to sponsor evaluation of all university post-graduate programs. The evaluation is being performed by the Commission on University Education in Hospital Administration, of which leading hospital administrators are members. There is a full-time director and an assistant director; the commission is being financed by the W. K. Kellogg Foundation.

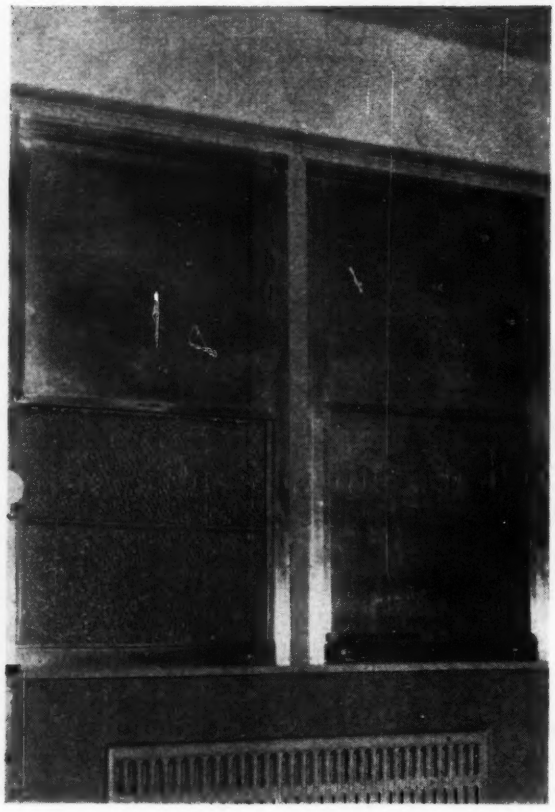
Other Countries

Canada and the United States are not the only countries who are striving to pass on the basic principles which will lead to better hospital administration. Very briefly, here is what is taking place elsewhere.

In Great Britain, the universities still do not recognize any responsibility for the teaching of management as such, in any form. However, the demand for training in basic principles of hospital administration is there and the Hospital Administrative Staff College, established by the King Edward's Hospital Fund for London, completed its first year of operation in April, 1951. The college conducts short refresher courses for senior administrators and provides a two-year training course for men already employed in the hospital service. Ten months of the two years are spent at the staff college and the remainder of the time in hospitals for the purposes of practical work and experience. This longer course is patterned somewhat after ur graduate program in Canada and those in the United States.

In Australia, a course consisting of tutorial lectures, published in booklet form, has been prepared within the past two years. The syllabus is divided into four parts, each dealing with a different phase of hospital administration, with a booklet on each part. This new educational program is conducted by the Australian Institute of Hospital

(Continued on page 76)



Aluminum Blinds for the Dark Room

The Port Colborne General Hospital, Port Colborne, Ont., has found a new use for aluminum as blinds for the dark room. Storm windows, of aluminum-frame construction, containing two aluminum sheets in place of glass, have been installed on the inside of the window in a room where darkness is desired. As shown in the photograph, (left), these aluminum sheets are removable, since each sheet fits into a grove at the side of the frame with a spring behind it. Thus the aluminum can be easily removed if daylight is desired and re-inserted when darkness is required.

The hospital first installed this type of blind, on an experimental basis, in the emergency room where some fluoroscopic work is done. Now that the blinds have proved satisfactory there, they will also be installed in windows of the x-ray department and operating rooms.

These aluminum windows were installed by a local agent for a cost of approximately $36 a piece for a window sized 5½′ by 3′. This is no more than the cost of purchasing the black roll type blinds which do not have the lasting qualities that aluminum blinds have.

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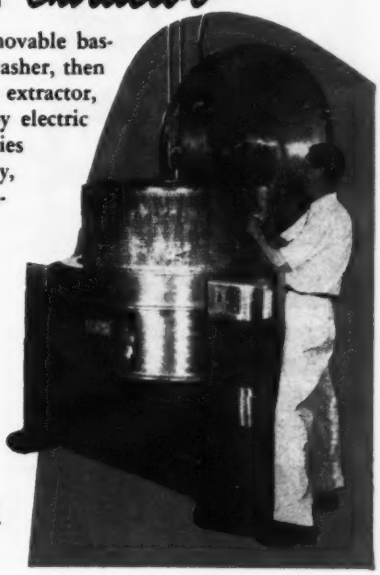

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Better Hospital Administration

(Continued from page 74)

Administrators and is a means of preparing candidates for the regular examinations conducted for the advancement of hospital administrators in that country.

In 1950, the first graduate program in hospital administration in Latin America was organized in the School of Public Health of the University of Santiago, Chile. Then, during 1951, the school of Sao Paulo, Brazil, got underway and one at Mexico City is also being established. The programs I have just mentioned are also being assisted financially by the W. K. Kellogg Foundation.

In Canada Today

What is taking place in Canada today to make these basic principles for better hospital administration available to a greater number of hospital personnel? In 1947, the post-graduate course in hospital administration was established at the University of Toronto, under the direction of Dr. Harvey Agnew, with Dr. L. O. Bradley as associate professor. Shortly thereafter Miss Eugenie Stuart, a graduate of the program at Northwestern University, joined the staff. The course consists of one academic year at the School of Hygiene, University of Toronto, and a 12 months' residency at selected hospitals either in Canada or the United States. Approximately 50 students have received training under this program.

The year after the post-graduate course started at Toronto, a training program got under way in the province of Quebec. This program is conducted in the French language and consists of a two-week session designed to provide formal training for administrators of all hospitals. These courses are available for anyone wishing to attend and, as would be expected, the greater proportion of the students are Sisters. Since its inception, the course has been progressively enlarged in scope and extended to include assistant administrators and some department heads. Each year, a two-week session is held for new students and another two-week session for advanced students. As a result, some of the original students of 1948 have completed ten weeks of formal training.

In addition to the above sessions, special courses usually of one-week duration have been held in such departmental areas as medical records, pharmacy, laundry, and accounting. Two-week sessions are also being conducted for directors of nursing schools and for those in charge of teaching. All told, there have been 650 students enrolled in these regular and special courses.

This training program, which is under the direction of Rev. Father H. L. Bertrand, is a very outstanding development in the field of formal education for hospital personnel in Canada. It is really a form of undergraduate training which is paving the way for the establishment of a post-graduate program in the French language.

In 1950 an apprenticeship type of training program was put into effect at the Vancouver General Hospital. It was similar in many respects to the one conducted by Duke University, to which I referred earlier. The major significance of this initial action taken by the administrator of the Vancouver General Hospital was that from it an undergraduate course for the training of hospital administrative personnel was developed at the University of British Columbia the following year. This course is included as one of the options for specialization in the School of Commerce at the University of British Columbia and, upon satisfactory completion, the student receives a Bachelor of Commerce degree and a diploma in hospital administration from the University of British Columbia. The course is rather unique in that it is divided into four phases, the first being three years of general education at the university level; the second, two years of specialized education at the university, introducing students to professional backgrounds and practices in such subjects as law, finance, personnel, industrial relations, hospital administration, et cetera. The third phase of seven months' instruction and apprenticeship is given at a hospital and includes, for example, general organization and management, departmental management, and specific practices and techniques of the various professional and administrative groups. The fourth phase takes ten months and consists of practical experience in the various departments of different hospitals. The first students in this new course are due to graduate this year: therefore, it is not yet possile to assess the place that this type of training will

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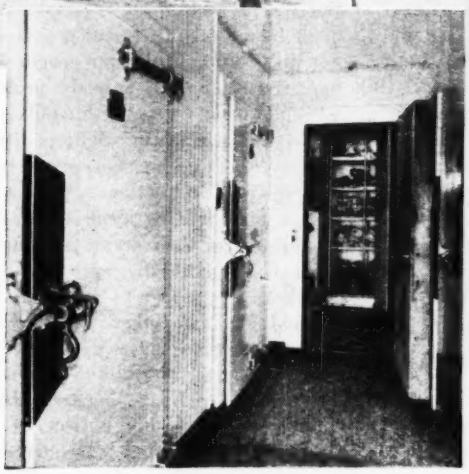
Mother-House of Les Filles de la Charité du Sacré-Coeur, Bowen Ave., S., Sherbrooke, P.Q.



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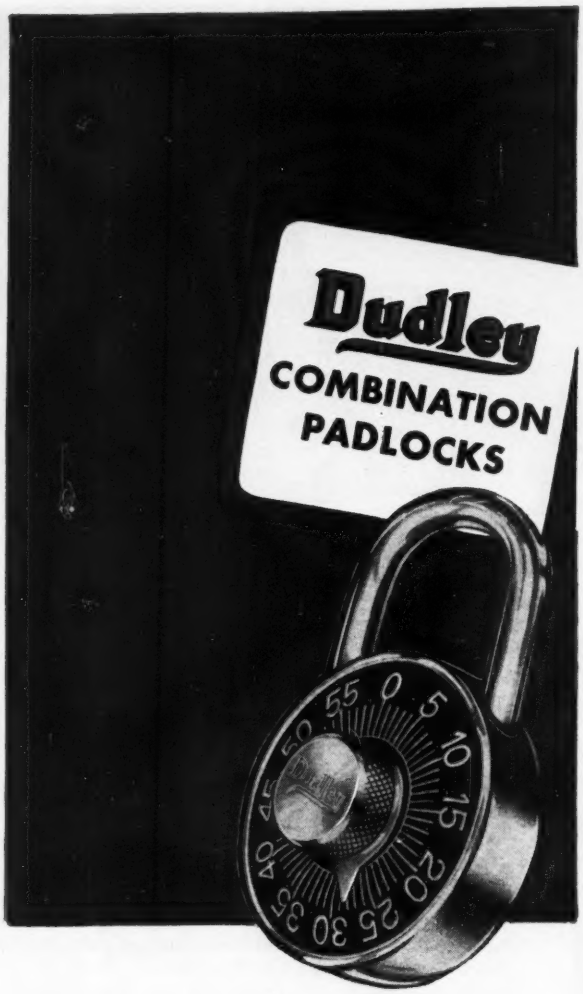

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Large numbers of people throughout the world live on all-vegetable or meatless diets, Dr. Mickelsen pointed out. But the proteins from vegetables and plant foods, such as cereal grains, are not quite enough to keep people well nourished. Some animal protein, whether meat, eggs, fish, milk, or poultry, is needed in addition. Antibiotics, recent experiments show, have a protein-sparing action. That means that a little fish or meat in the diet would go farther in terms of nourishment if an antibiotic were added to the diet.

In India and other parts of the Orient where rice makes up most of the day's food, the antibiotics might be particularly useful, it appears. Heretofore, the nourishing effect of the antibiotic has been considered a growth-promoting and weight-increasing effect. This has led to extensive use of antibiotics in poultry and swine feeding. — *"X-ray News", January, 1953.*

Make Sure Blinds Are Secure

Have the venetian blinds on windows in your institution been checked lately? It is important that this be done periodically. Reports received by the accident reduction department of the Hotel Association of New York City indicate that falling blinds have caused severe accidents in a number of cases.

Accidents of this nature can be reduced to an absolute minimum by having a maintenance employee make a periodic check to see that all blinds are securely fastened at the top. In that way, it will not be possible for blinds to fall if operated normally. — *Institutions Magazine.*

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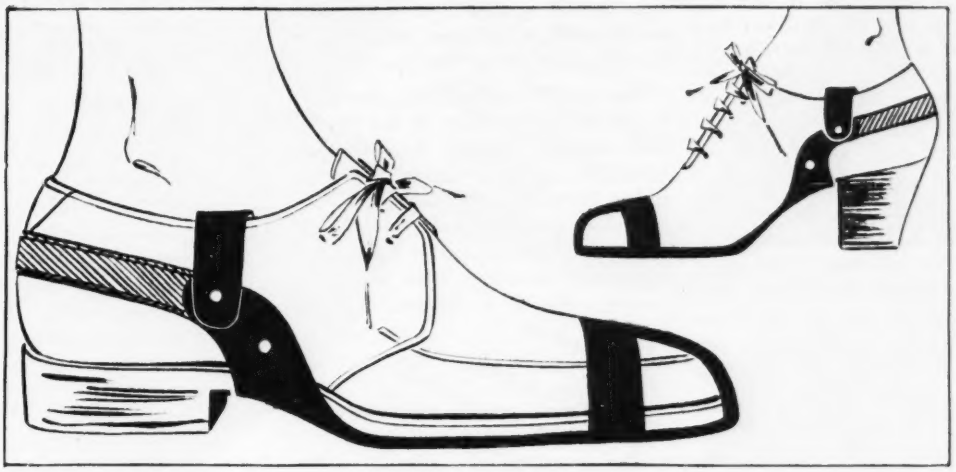

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With the Auxiliaries

Auxiliary at Port Hope, Ont. Lauded for Year's Activities

At the 1952 annual convention of the Women's Hospital Auxiliaries Association, Province of Ontario, a prize was given for the best three minute report on an auxiliary's work during the year. The ladies' auxiliary to the Port Hope Hospital, Port Hope, Ont., received the award. It was felt, by the judges, that this auxiliary had accomplished a valuable service, not so much by the amount of money raised but rather by the number of people it had influenced to contribute to the hospital.

The report reads in part: "We consider the best effort of our auxiliary for the year to be our attempt to develop in our community the spirit of goodwill toward the hospital. The auxiliary may or may not be given credit, financially or otherwise, but in all cases the hospital has benefitted.

"For example: the Masons have given easy chairs to the men's semi-private rooms; the Eastern Star is refurnishing the women's semi-private rooms; the Women's Institute made a gift to the children's ward; the I.O.D.E. made a contribution to the nursery and purchased lamps; a rural woman's plum tree yielded an abundant crop and, with sugar donated by friends, she made jams for the hospital; a woman made a pair of pillowslips on which two children sold raffle tickets and gave the money to the hospital; a group of girls raffled a table centre and donated the money to the hospital; and a local drama group gave the net proceeds from a play.

"The Women's Association of a country church contributed the money realized from a repeat performance of a play they had produced; the East Neighbourhood Club gave thermos jugs to the hospital; and an old age pensioner, pleased with the care she had received in hospital, made marmalade for the institution. Several women, both in and out of town who are friends of auxiliary members but not members themselves, have been sewing for the hospital. These women, in turn, influence their friends to work for the hospital. Farm women, living near the Governor General's summer home, have gleaned peas from the estate and processed them for the hospital.

"Thus the spirit of co-operation, collaboration, and dedication to a worthy cause is spreading through the area in and around Port Hope and the hospital is winning friends and gaining materially at the same time."

Another interesting report, presented by the ladies' auxiliary to the Brantford General Hospital, showed highlights of a year's work in coloured slides. These depicted inside and outside views of the hospital, the capping ceremony, presentation of gifts and equipment, as well as other important events— *Mrs. J. E. Buchan.*

* * * * *

National Council of Auxiliaries to Hold Biennial Meeting in May

The second biennial meeting of the National Council of Hospital Auxiliaries of Canada will be held at the Chateau Laurier Hotel, Ottawa, from May 18th to 20th, in conjunction with the biennial meeting of the Canadian Hospital Council. Proposed plans include an informal reception at the Chateau Laurier on Sunday, May 17th.

The Council's president, Mrs. O. W. Rhynas, Toronto, will preside over the sessions. Representatives are expected from each provincial association, all of which have the privilege of sending four delegates to the meeting. An open session will be held for auxiliary members who wish to attend the meeting.

Members of the national executive are: Mrs. James D. Good, London, Ont.; Mrs. Harold Wilkes Davis, Kingston, Ont.; Mrs. James Ross, Truro, N.S.; Mrs. Ernest Haggerman, Saint John, N.B.; Mrs. John Oliver, Edmonton, Alta.; Mrs. J. Milton George, Morden, Man.; Mrs. W. P. Fillmore, Winnipeg, Man.; Christina Macleod, Winnipeg; Mrs. W. B. Frost, Melfort, Sask.; Mrs. S. S. Alexander, Swift Current, Sask.; Mrs. Forbes Perkins, Vancouver, B.C.; and Mrs. Claude R. Wilson, Vancouver. Mrs. W. R. Whiteside of Windsor, Ont., has been appointed to assume the office of secretary-treasurer of the national council, which was left vacant by the death of Mrs. T. J. Lytle, Toronto.

* * * * *

Montreal Women Meet to Form Provincial Auxiliaries Association

Steps have been taken to form a provincial association of women's hospital auxiliaries in the province of Quebec. An executive committee has been appointed and for the present it is to be known as a planning committee. The members are: Mrs. J. C. McDougall, president; Madame Paul Bienvenu, vice-president; Mrs. Alton Goldbloom, vice-president; Mrs. Alexander Hutchinson, vice-president; Madame J. S. Boutin, honorary secretary; Mme. René Gagnon, honorary treasurer; and Mrs. N. A. Prentice, honorary secretary. One meeting has been held and much interest has been shown by the French, English, and Jewish voluntary auxiliaries which serve the hospitals in Montreal.

* * * * *

Busy Days Ahead for Auxiliary at Women's College Hospital, Toronto

The ladies' auxiliary to the Women's College Hospital, Toronto, Ont., undertakes to supply equipment needed at the hospital which the board of governors feels it cannot buy. After studying these needs the auxiliary then plans how to raise money to purchase the equipment. Funds are raised by sponsoring a tea in the spring, a bridge in the fall, and the annual "January Night". Recently the auxiliary purchased a machine to record the progress of operations, which can be played back to hear the exact steps taken. The travelling tuck shop is one of the auxiliary's projects and members knit and sew articles to sell in the shop in the hospital's foyer. A team of 11 women is currently working on the hospital's campaign for funds.

"Doctor", said a patient to me, "I hope you will be different from the many physicians whom I have consulted. I hope you will examine the x-ray films less and me more."—*Dr. Herrick.*

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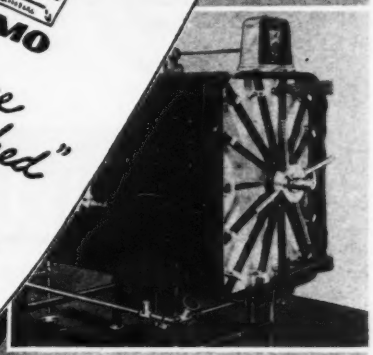

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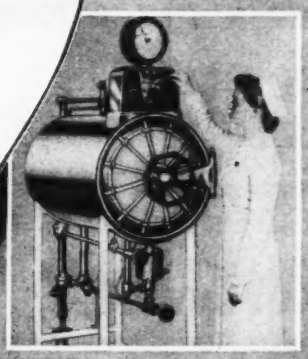

MEMO

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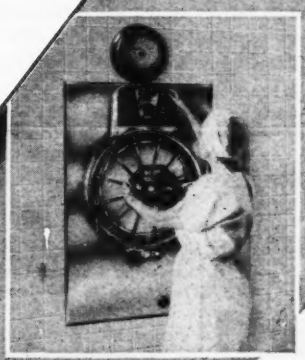

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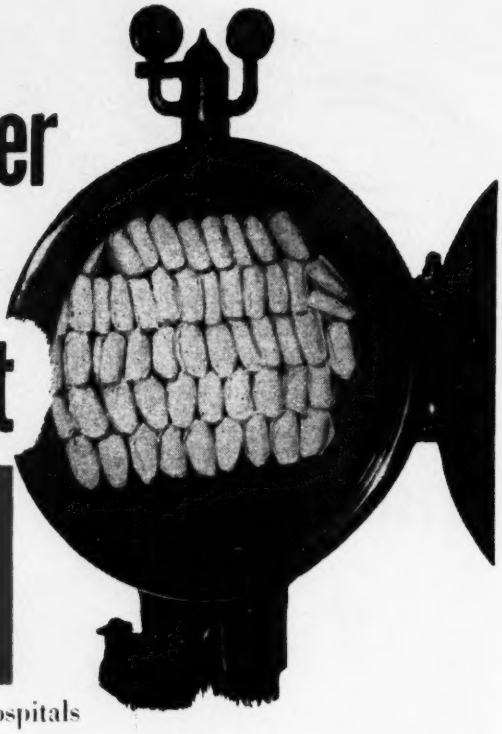

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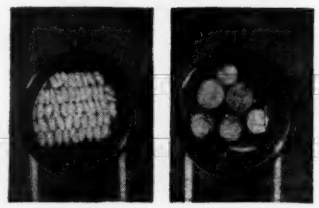

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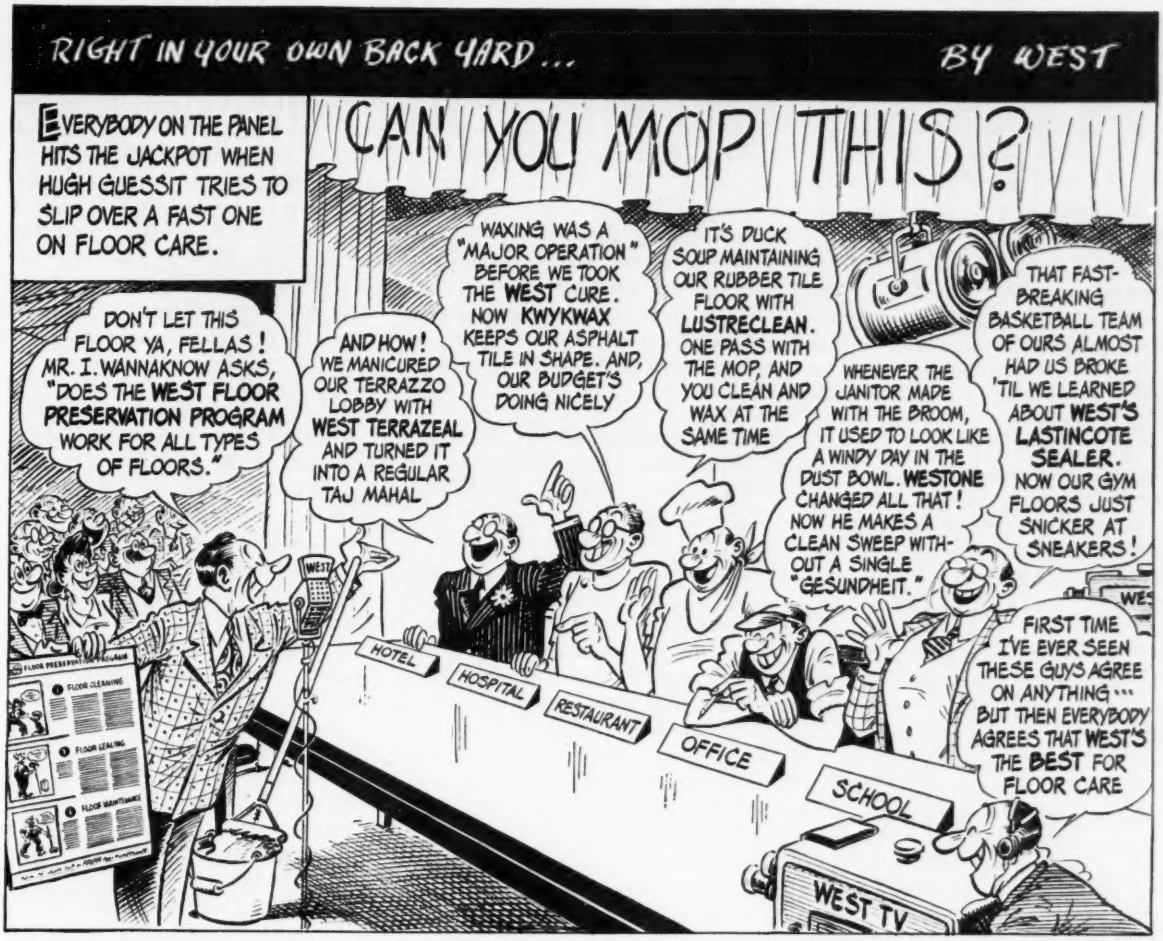
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EVERYBODY ON THE PANEL HITS THE JACKPOT WHEN HUGH GUESSIT TRIES TO SLIP OVER A FAST ONE ON FLOOR CARE.
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DON'T LET THIS FLOOR YA, FELLAS! MR. I. WANNAKNOW ASKS, "DOES THE WEST FLOOR PRESERVATION PROGRAM WORK FOR ALL TYPES OF FLOORS."
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IT'S DUCK SOUP MAINTAINING OUR RUBBER TILE FLOOR WITH LUSTRECLEAN. ONE PASS WITH THE MOP, AND YOU CLEAN AND WAX AT THE SAME TIME
WHENEVER THE JANITOR MADE WITH THE BROOM, IT USED TO LOOK LIKE A WINDY DAY IN THE DUST BOWL. WESTONE CHANGED ALL THAT! NOW HE MAKES A CLEAN SWEEP WITHOUT A SINGLE "GESUNDHEIT."
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FIRST TIME I'VE EVER SEEN THESE GUYS AGREE ON ANYTHING... BUT THEN EVERYBODY AGREES THAT WEST'S THE BEST FOR FLOOR CARE
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Colour Television

(Concluded from page 45)

down upon and easily observe the operating field. Thus the colour technician must frequently compare the colour of the image on the camera control console screen with the colour of the televised subject, because the ability to duplicate a colour from memory is of extremely short duration.

Receiver

The colour television receiver, furnished as standard equipment with an installation, is a cabinet-type set which, with the exception of the colour filter disk, corresponds in function to the commercial television set for home use. Basically, the receiver is a "slave" unit in that it merely repeats the picture originally received at and re-transmitted from the camera control console. There is no practical limit to the number of receivers that may be on the line, the receivers being connected from one to the other in series fashion. When using the signal cable normally employed with a standard installation, the most distant receiver may be as far as 500 feet from the camera control console. By employing special cable, which involves no change in conduit specifications, the distance may be increased to 1,000 feet and beyond this distance, a line video booster amplifier is generally required. The standard receiver gives a 12½" picture which will accommodate comfortably an audience of twenty-five to thirty persons, this number being able to see the most minute detail with complete comfort. Because of the current relatively high cost of large screen receivers, it is more economical, at this time, for a hospital to plan on installing a sufficient number of 12½" units to accommodate their maximum anticipated audience. Projectors employing theatre-type screens are currently being developed but these will not be available for several years, at least, and present estimates of cost indicate that this factor will be a prohibitive one for some years. At such time as units of this type are available, however, they will be readily adaptable to present picture-taking and monitoring equipment without modification.

Power

The power supply unit operates from a 115-volt, 60-cycle, single phase source of AC power at 1.8 KW and delivers an electronically regulated source of DC voltage to the camera control console.

From a personnel standpoint, the operating technician employed by the the hospital to operate the equipment should be an individual with practical experience in television, although a specific knowledge of colour television is not necessary. It is definitely inadvisable that an operator be chosen who lacks such a background of fundamental training in electronics.

We have, so far, limited ourselves to the consideration of a closed circuit system—in other words, one in which the signal from the camera to the receiver is carried over intra-mural cable and conduit. Actually, however, there is no limit to the distance over which a program can be transmitted. Short run, inter-mural programs involve merely the extension of the coaxial signal cable, with distribution and stabilizing amplifiers being introduced as necessary. With such an installation, the distance to the farthest receiver should not exceed one mile. Longer runs and inter-city telecasts can best be handled by microwave relay. Unlike radio, television waves are not reflected by the high altitude layer of atmosphere; but act more like light and travel in a straight line. As a result, microwave relays, employing highly directional shortwave receiver-transmitter stations, are located not more than twenty to thirty miles apart at points of maximum elevation and relay the transmission on a line of sight principle.

Inter-city Telecasts

Inter-city telecasts of surgical operations are actual fact and not mere hypothesis, the first one having been made on December 6, 1949, when a program was transmitted by microwave from Johns Hopkins Hospital in Baltimore to the American Medical Association convention in Washington. D.C. Several of Smith, Kline and French's programs, utilizing the coaxial cable facilities of national networks, have included transcontinental telecasts, the most spectacular having been in December of 1951 when an hour-long heart operation to correct a constricted aorta was carried from a Los Angeles hospital to surgical gatherings in Chicago and New York. Facilities for a permanent inter-city installation are being planned at this time by a mid-west medical college that will use microwave relays in conjunction with two other hospitals some five miles distant. One of the hospitals will have its own camera installation and will exchange programs with the medical college, while the second hospital will have only receiver installations for the reception of programs.

As we view, then, the imminent completion of plans for the first inter-hospital and inter-city colour television installation, we are able to appreciate the tremendous strides that surgical and medical television has made in the past six years. Doctors have witnessed the miracle of colour sweeping aside the shortcomings of the earlier black-and-white programs and medical colleges have available to them today perfected equipment engineered to their exacting needs. To the student of tomorrow, teaching by colour television will undoubtedly be routine; but it is reasonable to anticipate that it will forever be recognized as one of the truly major developments in surgical and medical education.

Coming Conventions

May 17-20—Annual Convention of the Canadian Society of Laboratory Technologists, Macdonald Hotel, Edmonton, Alta.
May 18-20—Biennial Meeting of the Canadian Hospital Council, Chateau Laurier, Ottawa.
May 25-30—International Hospital Congress, London, Eng.
June 10-12—Annual Meeting of the Maritime Hospital Association, Algonquin Hotel, St. Andrews, N.B.
June 29-July 3—First Joint Convention of the Canadian Society of Radiological Technicians and the American Society of X-Ray Technicians, Royal York Hotel, Toronto
Sept. 7-12—International Congress of the World Confederation for Physical Therapy, Central Hall, Westminster, London, Eng.
Oct. 13-15—Annual Convention of the Associated Hospitals of Manitoba, Royal Alexandra Hotel, Winnipeg, Man.
Oct. 19-21—Annual Convention of the Associated Hospitals of Alberta, Macdonald Hotel, Edmonton.
Oct. 26-28—Ontario Hospital Association Convention, Royal York Hotel, Toronto.
Oct. 27-30—Annual Convention of the British Columbia Hospitals' Association, Hotel Vancouver, Vancouver, B.C.

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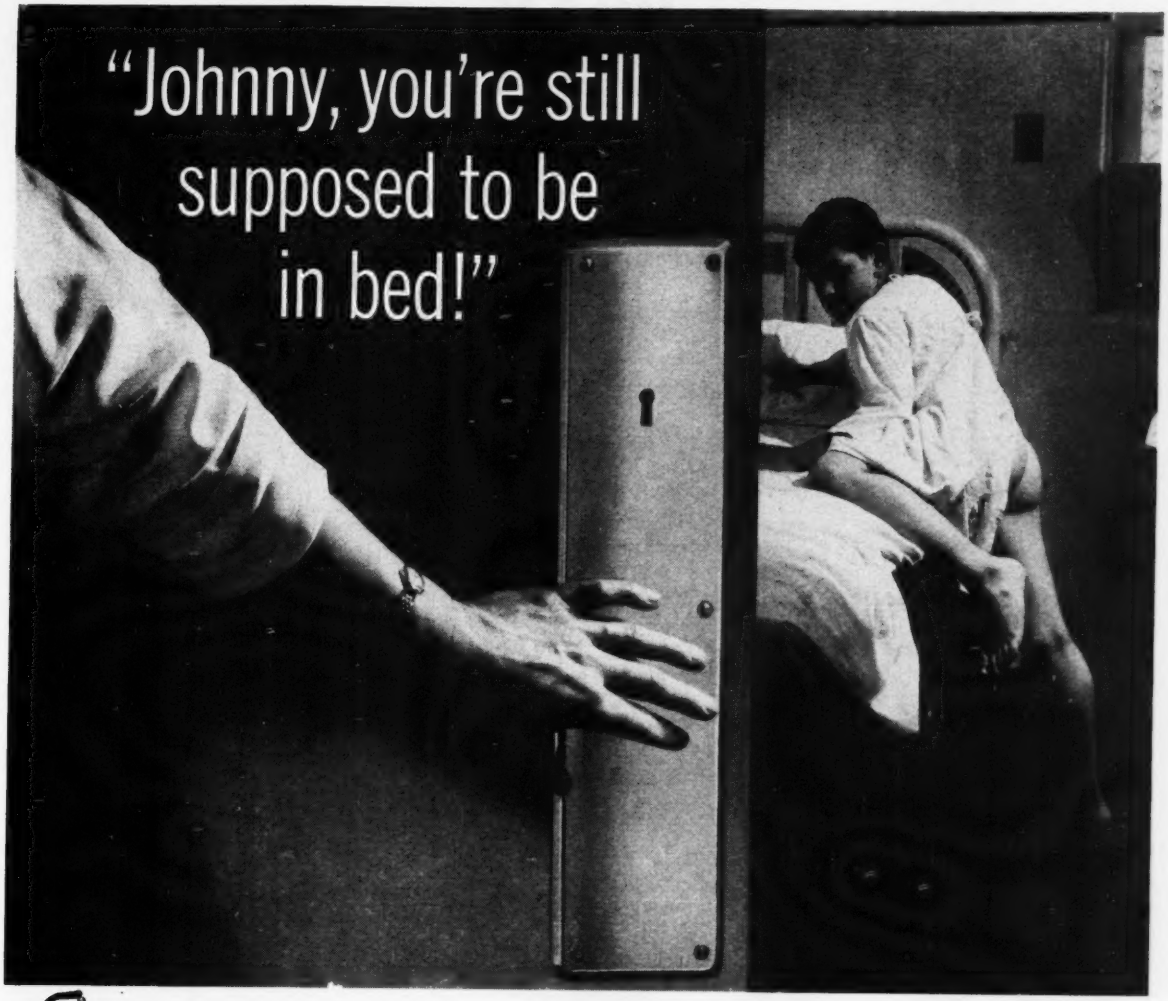

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1. Fox, C. L. Jr., et. al.: An Electrolyte Solution Approximating Plasma Concentrations with Increased Potassium for Routine Fluid and Electrolyte Replacement, J. A. M. A., March 8, 1952.

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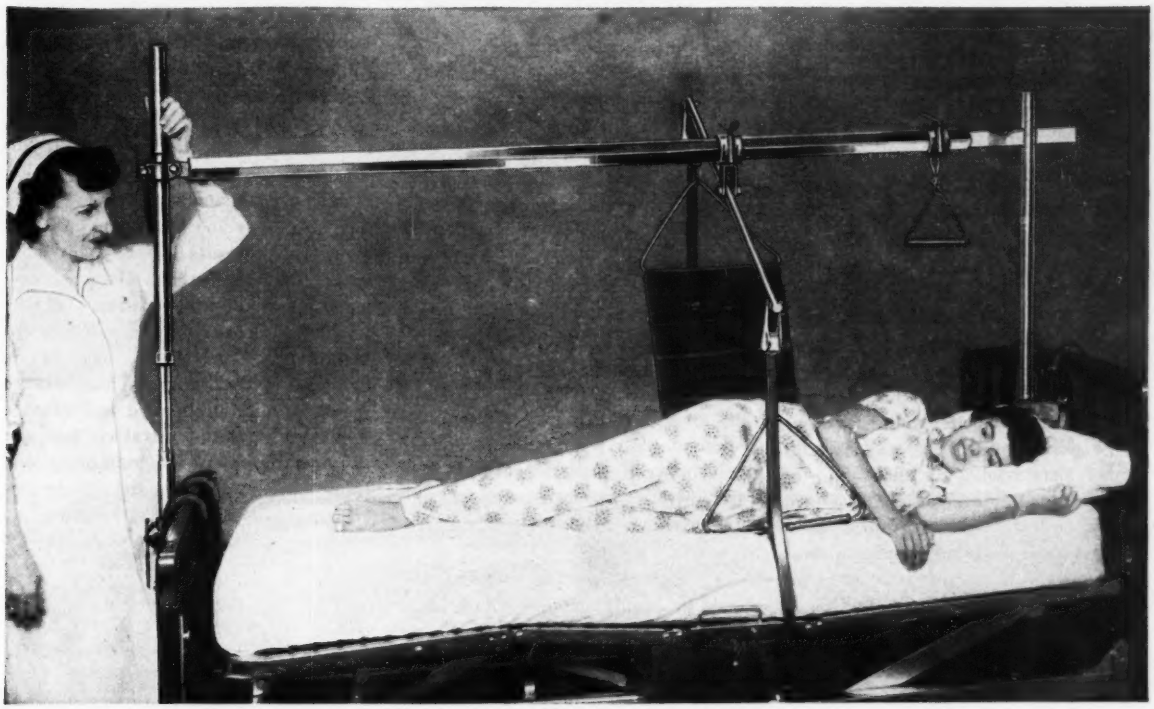
NEW!

Doctor Plymale Hydraulic Lift Frame



This frame employs a new principle of simple hydraulic pump elevation. Two-finger pressure raises the heaviest patient. To lower, rotate the handle. The universal mounting fits on any hospital bed.

The Plymale frame increases patient comfort. Healing often is speeded and complications which frequently occur in long confinements avoided. Nursing care is simplified, heavy lifting eliminated.

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To prevent bed sores.
Assisting bed pan use.
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Leg held in internal rotation by gravity.
Keeping hip completely mobile for early exercise.
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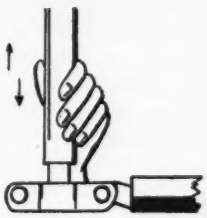
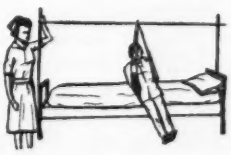
DROP US A NOTE TODAY FOR COMPLETE DESCRIPTIVE LITERATURE.



1. RAISING, LOWERING PATIENT — Two-finger pressure raises the heaviest patient; rotate handle to lower.

2. FOR BEDPAN USE—Place obese patients or patients in traction easily and safely in position.

3. TURNING PATIENT— Fasten one side of pelvic sling to frame. Raise frame until patient is turned 10-180° as desired.



4. STANDING PATIENT UI —Raise patient in pelvic slin by raising frame. Swing pa tient across bed and tilt hin up until he can step from sling.

De Puy MANUFACTURING CO., INC., Warsaw, Indiana

In-service Training

(Concluded from page 47)

bers of each of the various divisions so as to promote a better understanding of the problems confronting each group by all those represented. Then it will also be necessary to have some of the program carried on for each of the professional groups separately so that they can deal with their own fields of activity. In the small hospital, the professional staff may all work in one group and the lay personnel in a second group, as planning will have to be greatly simplified.

The program worked out for the nurses' aides, orderlies, ward aides, ward maids, laundry and kitchen help cannot, of course, be as extensive as that for the professional groups but must be worked out at the level of these workers. A better understanding can be developed in this way among the lay personnel. As they gain a better understanding of the various hospital policies, elementary principles in the over-all program, et cetera, they will develop not only better relations with each other but with the public.

In our whole problem let us not forget the office workers and telephone operators. Working in a hospital office is not the same as working in any office. Here we are dealing with sick people or their relatives and our p-roach must be both tactful and sympathetic if we are to develop a public that feels a sense of security in our institution. This fosters the much-needed good public relations that the hospital must have in the community. Hence it is very certain that we must include these staff members in our in-service educational program.

Types of In-service Training

Orientation. The scope of the department's work can be demonstrated to the new staff members during the first month of service. Visits should be made to the various parts of the hospital. The heads of these departments should be introduced and should be trained to present brief information concerning the purposes of the work of the service and any interesting features about it. The leader responsible for the planning of the orientation program must be ever vigilant to make sure that the department head does not feel he is being intruded upon.

Staff Meetings. These may be meetings open to the entire staff or a single professional group. The purposes of the meetings may vary. They may be confined to instruction or interpretation by a chief of a department; but they have far greater learning value if staff members are encouraged to carry on discussion freely after the lecture.

The "informational" meeting can be planned so that people outside the hospital staff are brought in. Here we find an excellent means of broadening the horizons of the group so as to make them aware of people and r-ganizations outside the walls of their institution who carry on related work and, like themselves, form a link in the vast chain of community service.

It is of value to have the seminar type of meeting. Here, certain individuals are chosen to present original material and lead discussion. This provides an opportunity for staff members to defend their own opinions, distinguish between professional and personal criticism, acquire respect as a person, and recognition as a fellow worker and member of the team.

Staff participation in problem solving. In small groups, opportunity should be given for problem-solving. The members of the group may come from a number of services or different work groups in the hospital. The chance for consultation is thereby provided, with the additional opportunity to develop new techniques or hospital policies. The members learn objective evaluation. They begin to appreciate the value of participation in problem-solving. Often staff members who have resented or even defied changes brought about by other means come to see their worth when they actively participate in a research project.

Day-to-day in-service training. The respect that is developed between supervisors and staff can, to a large degree, facilitate the attainment of objectives in an in-service program. Team work is stimulated through respect for the employee as an individual, provision for group participation and planning, and through special tasks and assignments for presentation to committees and at meetings. It is a constructive development of team work that will pay the biggest dividends in any in-service program. This is very well summed up by Allan Brown in the *Technology Review* of May, 1947. He says: "Human progress depends upon concert of endeavour. For all that we have, for all that we hope to gain we depend upon associated effort. Civilization depends upon the endeavour of individuals associated in their respective enterprises."

Conclusion

Compensating returns on an in-service program will not be immediately perceptible and are certainly not easily demonstrated. However, planning takes time and must be sound. Haphazard make-shift in-training programs will not justify themselves nor their encroachment on staff time. Remember the whole program demands an optimistic attitude coupled with three other essentials — constancy, consistency, and co-relation. It demands a broad outlook in present planning so that results will be in evidence in the future. There will be plenty of discouragement and often a feeling of total frustration but the minor successes will become more and more apparent as the in-service program develops and becomes an accepted part of the total hospital program.

Two New Anti-Tuberculosis Drugs Available on Prescription

Federal health authorities have relaxed restrictions on the two drugs, isoniazid and iproniazid, which now may be purchased on prescription from a doctor. Formerly, they were available in Canada only for research in tuberculosis sanatoria, hospitals, and other medical research centres.

While relaxing restrictions, federal health officials warn that the drugs are not to be regarded as "cure-alls" but simply as another pair of weapons in the fight against tuberculosis. In general, research has not supported the optomistic hopes expressed when the discovery was first announced and it will be some time yet before sufficient data can be provided for a complete assessment of their value.

In the food and drug regulations, isoniazid is the term being used for isonicotinyl hydrazide or isonicotinic acid hydrazide and iproniazid is being used for 1-isonicotinyl-2-isopropyl-hydrazide. Both drugs are marketed under a variety of trade names.

The food and drug regulations have also been revised to place the salts of cortisone, hydrocortisone and its salts on the list of drugs available only on prescription.

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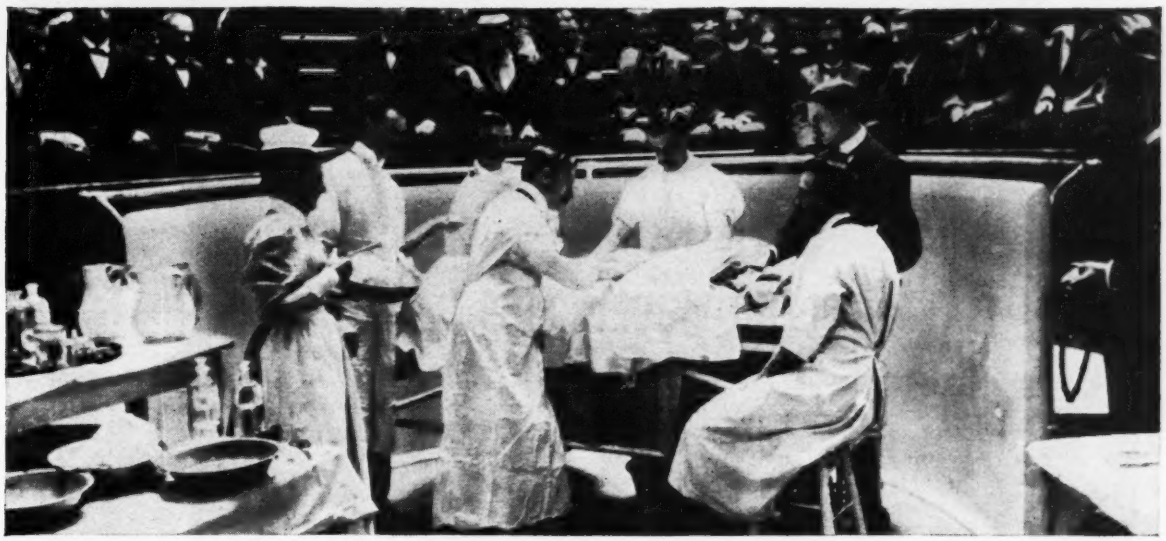

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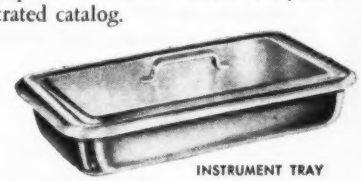

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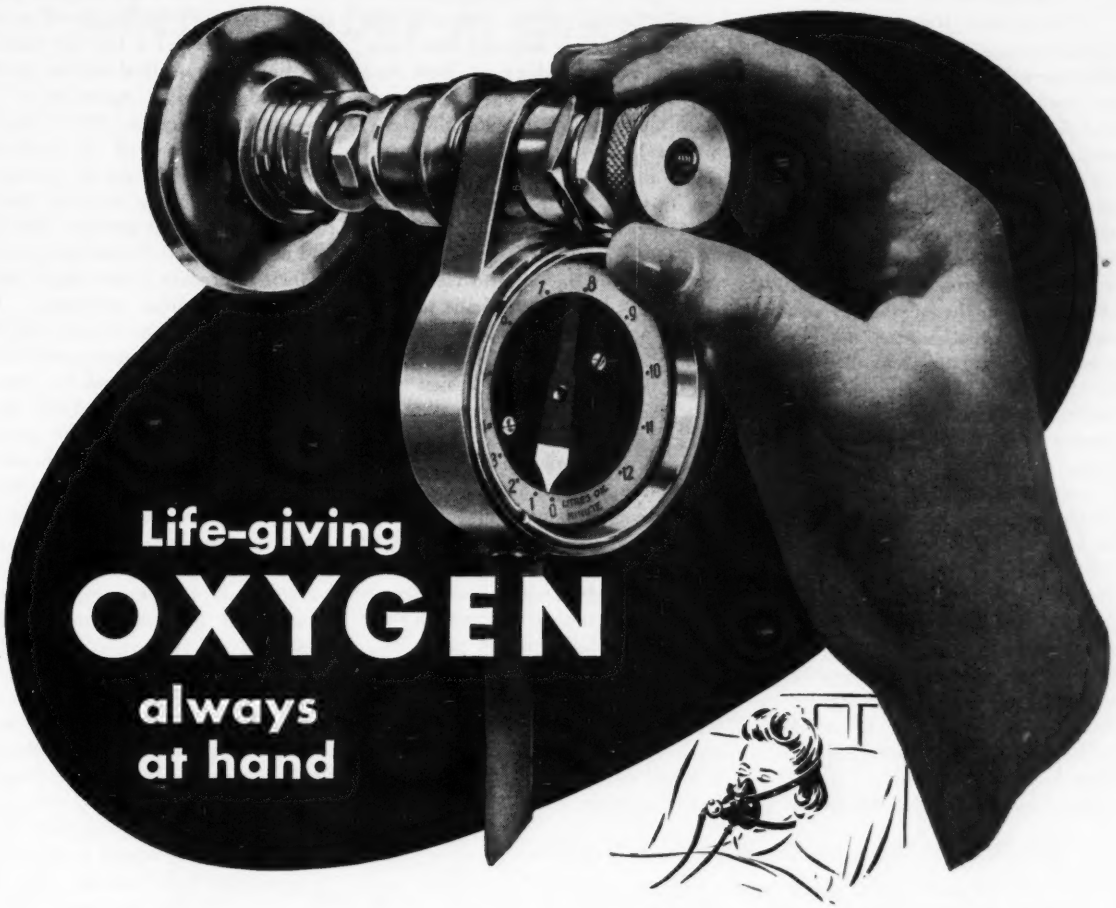

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Education or Service

(Continued from page 35)

which increased the number of available internships, that sooner or later the number of internships would exceed the number of applicants. For example, in the United States in 1900, there were 160 medical "schools" producing 5,214 graduates. By 1920, there were only 85 medical schools producing 3,047 medical graduates. This represents a decrease of approximately 45 per cent in the number of schools and 41 per cent in the number of graduates. This latter year (1920) was the first year when the number of internships available exceeded the number of graduating medical students. This trend has continued until, in recent years, there have been approximately two internships available for every medical graduate. In their 1952 report, the National Inter-association Commitee on Internships indicate that the hospitals participating in the co-operative matching plan for internship in the United States sought 10,414 interns; there were only 5,564 interns available. We do not have readily available figures for the Canadian situation but it is comparable.

Considerable time has been taken on the review of the developing trends in the relationship of the intern to the hospital since it is believed that many of the problems which we now face have their origin in trends which were established many years ago. Obviously, this development has introduced problems both for the graduate seeking internship and for the hospital seeking sufficient numbers of housemen to make their institution function adequately. From the point of view of the medical graduate it raises the problem of making a selection which will meet the needs of the individual. The problem of the hospitals is no easier. Since the intern rapidly learns that his services are in demand he may develop some of the characteristics shown by other individuals in a similar situation —he becomes demanding. The hospitals are approaching the problem by increasing the payment to the intern. Although it is usually easier to increase the monthly payment than to establish a good teaching program, is this not bound to emphasize the service aspects of an internship to the detriment of the basic function and the basic need of teaching? This problem is amply illustrated by two approaches recently made to our own medical school office. One was a hospital which agreed to pay all of the travelling and living expenses for a two-day visit by any final year medical student so that he could make an appraisal of the hospital as a place in which to intern. The other was one of our graduates who had agreed to go to a hospital where, although an excellent institution, there was real question that they had not organized the teaching aspects of their internship to the degree which we would consider adequate. This graduate advised one of our staff that he had accepted an appointment in this hospital and when asked his reasons stated, "Well, I am married and do not have too much money. This hospital offered me a good income, a house for my family, and a job for my wife."

We would not quarrel with the hospitals for spending more effort on the intern but we would ask the vital question — is internship to be an educational experience or a service function? If it is an educational experience, then more of this effort should be directed towards this end. Although there are some noted exceptions, this problem is particularly acute when the interns are going to hospitals which have no association with a university. Teaching hospitals provide this type of training largely as a result of their university affiliation. The problem naturally becomes more difficult when one considers the hospitals which are not fortunate enough to have the means of instruction provided by an outside body and where the attending physicians are concerned primarily with the daily practice of medicine. Surely some compromise must be made by more hospitals of the non-teaching group; those few hospitals, remote from a medical school, which have recognized this growing responsibility have been rewarded. The non-teaching hospitals must establish staff organizations and teaching methods comparable to those in teaching centres. The opportunity of obtaining extra graduate instruction is the primary reason for a recent graduate spending one year of his professional life in an internship.

Special Training

The facilities of the teaching centres for the training of residents and assistant residents have been, for many years, utilized for the preparation of specialists. Training in the first and subsequent years following

(Concluded on page 96)

O.M.A. Sponsors Conference on Medical Journalism

Medical journalism was the subject considered in a stimulating conference, sponsored by the Ontario Medical Association, which was held in Toronto on Jan. 16th. Arranged by Dr. W. R. Feasby, editor of the *Ontario Medical Review*, the conference was directed to all those engaged in any aspect of medical journalism — *i.e.*, advertising, editing, the pharmaceutical industry, the medical profession, and publication.

One of the purposes of the conference was to show the importance of developing "a discriminating group of medical editors who will curtail presentations which suffer from verbosity". Throughout the program, stress was laid upon the fact that, although the amount of medical literature published today is rapidly increasing, the amount of reading time available to the busy doctor is strictly limited.

The program was arranged in two forums. The first, under the chairmanship of Dr. A. D. Kelly, deputy general secretary of the Canadian Medical Association, dealt with the presentation of new pharmaceutical products to the medical profession, from the viewpoint of the detail man, the pharmacist, the advertising agency, and the doctor. The second panel, under the chairmanship of Dr. H. E. McDermot, editor of the *Canadian Medical Association Journal*, examined problems such as design and format, news gathering and writing, publication headaches, the value of planning ahead, and the use of language and grammar.

Speakers on both panels were informative and thought-provoking. Interest, on the part of the audience, was evident in the questions asked from the floor, although discussion time was very limited. The spacious auditorium of the Toronto Academy of Medicine provided excellent facilities for the conference. The interesting afternoon ended with a reception, held at the home of Dr. and Mrs. Feasby, whose gracious hospitality was enjoyed by all. ●

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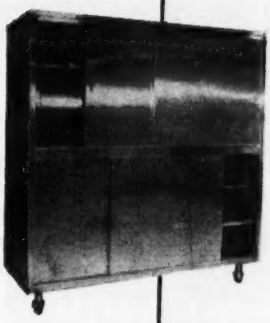

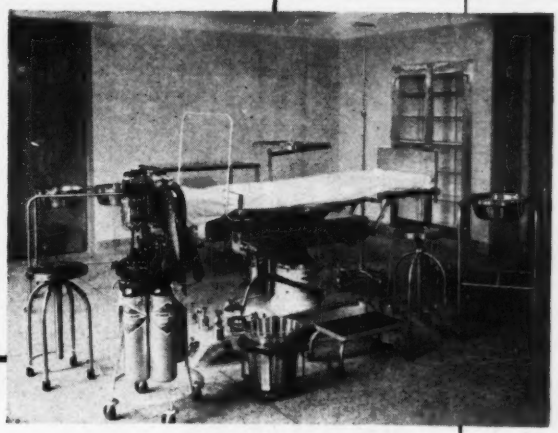

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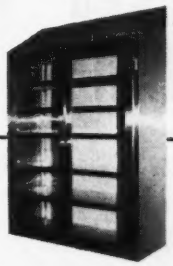

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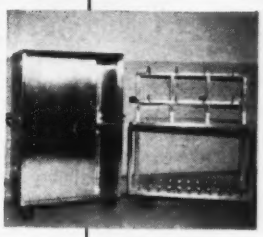

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Education or Service

(Concluded from page 92)

graduation is intimately linked with the number of teaching beds under staff supervision. This limits rigidly not only the number of undergraduates but also the number of interns and residents who may be taught adequately in any one hospital.

Here again it is so fundamental for the hospital and the university to work in the closest harmony, with mutual understanding, with a real sense of partnership, with common responsibilities, and with common objectives. Part of the education and training to fellowship level is carried out in the hospital proper, the outpatient department, the emergency department, the wards, the operating room, the delivery room, those parts of the hospital where the patients, the sick, and the injured, are examined, treated, cared for, and made well again. Part is carried out in the departments of pathology, bacteriology, clinical chemistry, and in the basic medical science departments of physiology, biochemistry, pharmacology, and anatomy—but all, in the university teaching entries, is carried out in the university teaching departments by university teachers. No line of demarcation is needed; no division is warranted. When the basic principle of dual responsibility for good instruction is accepted, the excellency of service rendered by the graduate, be he a rotating intern, a senior, or a resident, to the hospital and to the patient, is automatically assured.

Recently, the general practitioners have suggested that hospital training programs should be established to provide special training in that important field of medicine. This cannot be carried out in most teaching centres without seriously interfering with the existing training program for the preparation of specialists. To me, this need on the part of the general practitioner represents a real and serious challenge to our ability to effect an adequate solution to a problem which influences our whole population. Simply to refer the problem to the teaching hospitals is not enough; they are already over-extended in terms of their available teaching beds. This field would appear to present a real opportunity for the non-teaching hospitals. They have the beds which could be more fully utilized in teaching; they could well meet this urgent need. However, such a decision should not be made lightly, for there are responsibilities as well as advantages for the hospitals which assume teaching duties. Nevertheless, the problem must be faced; the opportunity to effect a solution should not be lost. The universities and the hospitals have a joint responsibility in meeting the educational needs of the young graduate in medicine.

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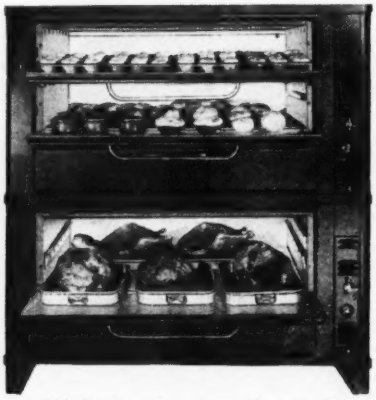

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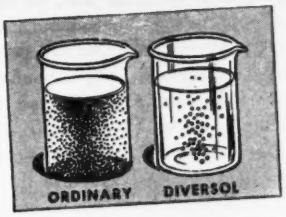

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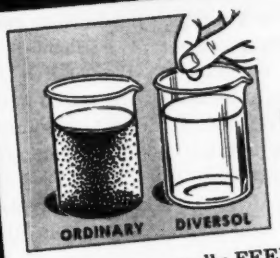

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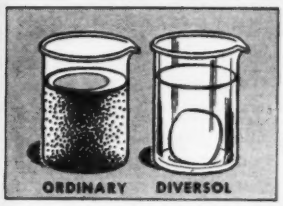

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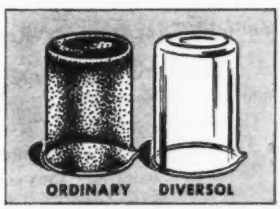
In this part of the test, green pads coated with an invisible grease film much like that often left on equipment, are floated on top of equal solutions of Diversol and another popular bactericide. The pad in the Diversol solution becomes wetted and bleaches out in a few moments. The pad in the other bactericide solution remains unchanged even after 10 minutes! This amazing penetrating action assures complete disinfection of treated surfaces.



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Medical Education

(Continued from page 52)

was continued for a period of two years when it was closed. We hear of Dr. Rolph again in 1832 when he began teaching a class until 1837. In that year he became a fugitive from justice because of his association with William Lyon Mackenzie. Rolph returned to Toronto following the amnesty in 1843 and resumed lectures. His school was then named the Toronto School of Medicine and his course, recognized by McGill, allowed his students to receive degrees from that university after a final year or so at that institution. In 1870, the Toronto School became the medical department of Victoria University.

In 1844, King's College Faculty was established in Toronto. It was a strong rival to the Rolph school but Rolph, who as a politician and a minister in the Hinck's cabinet, connived with the premier to pass a bill abolishing King's College in 1852.

In 1850, the Upper Canada Medical School came into existence. It was organized by James Bovell and eventually became the medical faculty of Trinity College. Bovell soon gained control of the General Hospital and Rolph's students were made to feel like "so much dirt in the wards and corridors". Because of religious difficulties, this school went the way of King's College and Rolph was left for a short period as Dean of the only medical school in Upper Canada.

Then came the revolt. Rolph's teaching staff deserted him and, joining with those from King's College, formed again as the Toronto School of Medicine — which after 31 years of useful endeavour was taken over by the University of Toronto. That this institution has prospered after the pangs of the early years goes without saying. It is after all the alma mater of Banting and the site of the Connaught Laboratories.

Schools in French Canada

The situation in French Canada is rather more complicated. There was established in Montreal, about 1843, a school wherein the teaching was bilingual. Appointees to the staff were expected to deliver their lectures, 150 per year, in both English and French. In order to cover the complete course, it became necessary to visit the student body twice daily, lecturing once in French and once in English. It speaks well for the instructors' command of the two languages that they were able to continue. This school, known as L'Ecôle de Medécine et Chirurgie de Montréal, was in some difficulty for clinical material but an arrangement was made with McGill to open the wards of the Montreal General and, later, for some time the wards of the Hôtel-Dieu were made available. For a time, students from this school were admitted *ad eundem* to McGill for the final year and were graduated by that institution. Later, a similar agreement was reached with Victoria University in Cobourg.

Laval University in Quebec received its charter in 1852 and medicine was taught there from its inception — as an amalgamation with the existing school begun by Francois Blanchet as the Quebec Dispensary about 1823. Incidentally, Blanchet was, as far as is known, the first native-born Canadian to be taught, apprenticed, and licensed in Canada. The school which he started went through the usual difficulties, closed eventually from lack of money; but his graduands continued to teach in St. Eustache and the Two Mountains area until Laval absorbed the school as its faculty of medicine. A branch of Laval was opened as a medical school in Montreal in 1878.

There were difficulties between the two French schools. Laval de Montréal was recognized by the clergy. The Montreal school was not. The latter found the wards of the Hôtel-Dieu closed to it and they remained so under the old agreement of a school being found rebellious to the Church and because of its association with Victoria University, a Protestant institution. This situation continued for some years, although some clinical beds were opened to students from the Montreal school until another order from Rome authorized the continuance of the school. The final change came early in 1919 when the University of Montreal was opened and the old "Ecôle de Montréal" was absorbed into its faculty of medicine.

Bishop's College Medical School, an offshoot of the Lennoxville College, was opened in Montreal in 1871. In 1890, it took what was then an advanced step in admitting women as students on the same basis as men. Like other schools of the same era it suffered from whims, vicissitudes, and lack of money. Following the death of its champion and advocate, Dr. F. Wayland Campbell, its activities ceased and it was finally amalgamated with McGill in 1905 .

The establishment of Trinity College.

(Continued on page 100)

New Program of Medical Education at Regina Geenral

A new program of medical education on the graduate level has been inaugurated at the Regina General Hospital, Regina, Sask., with Dr. M. G. Israels, one of Regina's leading internists, as director. With all the changes in medical education and the very rapid advances of medical knowledge, such a program will be of great value to the graduate and intern staff of the hospital, as well as to the physicians in the Regina area.

The Regina General Hospital has a bed capacity of 315 and thus provides a great deal of teaching material for the whole field of medicine. Intern responsibility and experience is being fostered by a definite allocation of teaching beds. At the present time the intern staff consists of a minimum of twenty-five junior rotating physicians and seven residents and seniors.

A scheduled supervised program of daily rounds, clinic lectures, and demonstrations has been arranged. Combined staff rounds are held each Saturday morning at 10.30 a.m. with representation from all the departments. Open discussion is fostered and the meetings may be clinical or take the form of a clinico-pathological conference.

Symposia on various pertinent subjects are held monthly. In these, emphasis is being placed on the recent advances in medicine in each field covered and a panel of four physicians leads the discussion. Special lectures round out the program.

All neighbouring physicians are being circularized to acquaint them with the program and invite them to attend as frequently as possible. Through this program those in charge and contributing are endeavouring to hold the standards of medical progress at a high level and to stimulate and maintain the interest so necessary in the practice of modern medicine. — *G. W. Peacock, M.D.*

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under the auspices of the Church of England, led to the opening of Presbyterian College in Kingston — to be known later as "Queen's". The medical school opened in 1854 with eight students some of whom were reportedly dissidents from Trinity in their final year. They were graduated in 1855 and the results were so encouraging to the administration that the medical school continued. There were difficulties here, too, but mainly those of clashing personalities. For the period from 1866 to 1892, the Faculty of Medicine divorced itself from the university and continued as the Royal College of Physicians and Surgeons, Kingston. However, in 1892, it again became the Faculty of Medicine of Queen's University and has so continued.

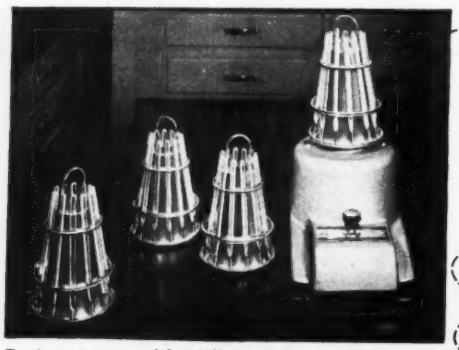
The Maritime Provinces, long a seat of learning, established Dalhousie Medical School in 1868. Due to the lack of hospital beds for teaching material, arrangements were made with McGill, Harvard, and New York, for the clinical years. Certificates of apprenticeship were still accepted as part of the course. In 1870, however, it was decided to give the entire course. It is recorded that a survey by the Carnegie Foundation in 1908 resulted in Dalhousie being marked for either extermination or re-organization. In 1920, the Rockefeller and Carnegie Foundations, impressed by the future possibilities of the school, donated one million dollars.

Upper Canada was fortunate in having a missionary in education in Bishop Hellmuth. He established, in 1863, schools for boys and girls in London. He separated the two by about two miles — a safe distance. He visualized London as a centre of culture and education. In 1830, he obtained a charter for Western University, now known as the University of Western Ontario, which was to have faculties for arts, medicine, law and theology. The law faculty died at the end of the first year, mainly because of financial undernourishment. The medical school which was, in the early days, self-governing, opened in a three-room cottage on the grounds of Hellmuth Boys' School. In 1910, it came under the control of the university and has continued to grow in numbers and stature.

How many of us are aware of the fact that there was, at one time, a Women's Medical College in Canada? In my readings, I came upon information that the Ontario Medical College for Women was established in 1883 and continued until 1906, during which time they enrolled 237 students. In 1906, their charter was surrendered.

In 1883, an agitation on the part of prospective students practically forced Winnipeg practitioners into opening the Manitoba Medical College in affiliation with the University of Manitoba, which had been in existence for six years. This followed on the threat of the opening of a proprietary medical school by a recent arrival. The long distances and the cost of travel for the students are instanced as the reasons for the precipitate opening. The qualifications for entrance to the school stand as a model for today inasmuch as they demanded two years of university with a four-year course and degrees to be granted by the university. Hospital facilities were granted by the Winnipeg General, St. Boniface, and Maternity hospitals.

(Concluded on page 102)



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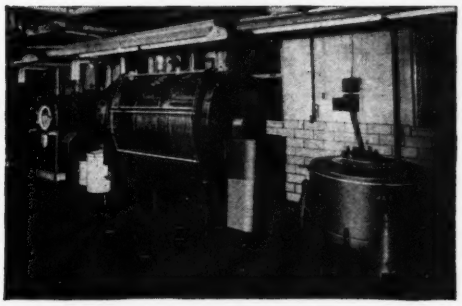
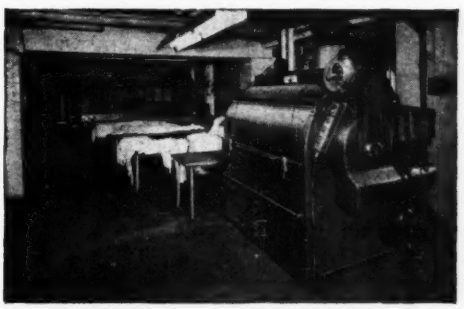


At far left, two new end-loading "Shell-Less" washers to supplement a previously installed 44 x 54 "Shell-Less", which was elevated for faster unloading. At right, a new 40-inch open-top extractor.



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A heavy schedule of overtime work, week after week — repeated need for sending laundry to outside processors — these were the "prices" paid by the 200-bed Children's Hospital for increasing service to its community. "What should be done about our laundry operation?"

A Hoffman laundry survey confirmed the fact that occupancy close to 100% (through the admission of adult polio cases) and work from a new nurses' home had established a basic laundry load greater than the existing equipment could handle or stay "caught up" with.

At the request of the Hospital's officials, two sets of plans for modernized laundries were prepared by Hoffman laundry engineers. One, for a new laundry in the existing floor space; the other, for an enlarged laundry in a building extension. Either arrangement provided a laundry operation matched to the needs. However, recalling the painful experiences of their soon-too-small, old laundry, Children's Hospital decided on the building addition. Installation of Hoffman laundry equipment has resulted in a reduction in the laundry work week and linen supply balanced to today's needs — capable of expansion to tomorrow's growth.

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INSTITUTIONAL ... DIVISION

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After the formation of the provinces in 1905, the University of Alberta came into being. Its charter is dated 1907 and land for the campus was acquired in that year. Men of vision must have been the instigators in the purchase. In 1907, the two towns of Edmonton and Strathcona vied with each other across the North Saskatchewan river. The land selected on the south side of the river was then in the open country and was covered with scrub poplar. How any one, in those days, envisioned the growth up to and around a campus is beyond belief. The medical school was born lucky in that it was conceived and born within the university. With the possible exception of Toronto, it is the only school in Canada which controlled its own hospital from the time of its opening in 1903. Until 1925, however, it did not graduate its own students, agreement having been reached with other schools for an *ad eundem* acceptance of its students after the pre-clinical years. In 1925 and each year since, studies have been completed in the province. With each year, the quality of the work would appear to be improving and, given time, it can be expected that the institution will take its place in the forefront of medical schools.

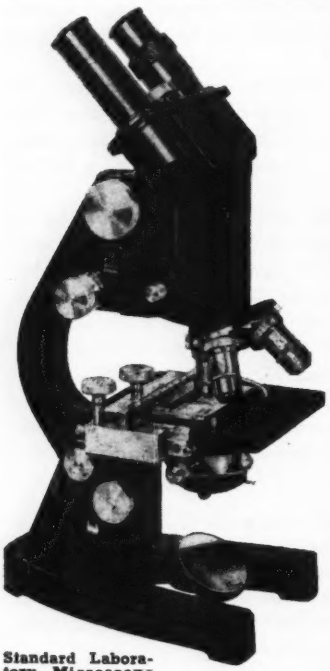
The infant among Canadian medical schools is to be found in British Columbia. While the charter dates back to 1908, it was not found possible to establish the school until 1950. A variety of circumstances contributed to the delay, not the least of these being two world wars, the depression years of the thirties, and various administrative details. These difficulties are now in the past and classes were begun in 1950 and the first graduates can be expected in 1954.

In their medical school, at present, the University of Saskatchewan demands two years in the Faculty of Arts and Sciences, two years in the School of Medical Sciences, and students are then admitted to other universities for their clinical years. This, as understood, will continue until the completion of the University Hospital, now under construction, when clinical beds will become available.

Nothing has been mentioned of the role played by those adjuncts to medical education — the medical journals. These have been many and varied and, with few exceptions, have been absorbed into the present organ of the Canadian Medical Association. The history of these journals would make a paper in itself and should provide an entertaining study.

With the increase in stature of Canada as a nation and her consequent development commercially, we are gradually approaching the position of our neighbour to the south as monies are becoming available for endowment. As an earnest of this the recent gift of one million dollars by R. S. Maclaughlin of Oshawa, Ontario, is noted. Where one has led, others will follow and a brighter era of post-graduate and research study can be forecast for Canadian medicine.

From the foregoing remarks it will be realized that, with one exception in the present Canadian medical scene, our schools are state-controlled and financed. Whether or not this is a good state of affairs remains to be argued. But it must be accepted as a fact that progress has been well and truly made. Whether we have to be thankful for our foundations laid on the solid European pattern or the control exercised by our governing bodies, I leave to the reader to decide.



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Notes About People

(Continued from page 66)

was formerly credit manager at the Kingston General Hospital, Kingston, Ont.

Mr. Mutter attended high school in Ottawa, Ont., and spent three years in the R.C.A.F. He had been with the Kingston General Hospital since March, 1947. He commenced his new duties in January.

* * * *

Felix George Reason

Felix George Reason, R.T., well known among radiological technicians, died on November 25th. Mr. Reason had been on the x-ray staff of the former Christie Street Military Hospital, Toronto, Ont., and had also served in the x-ray department of the Toronto General Hospital.

Always active in radiological circles, Mr. Reason had been one of the prime organizers of the Ontario Society of Radiographers, as well as one of its earliest presidents. He also helped to organize the Canadian Society of Radiological Technicians and became its first chairman in 1942.

* * *

Honours to Ralph H. Gale Upon His Retirement

Completing a long career of service which spanned more than 31 years, Ralph H. Gale retired at the end of December as director of the Saint John General Hospital, Saint John, N.B. He was succeeded by Dr. Carl R. Trask — (see *The Canadian Hospital*, June, 1952).

Many honours and gifts have been presented to Mr. Gale by staff members. At a general staff assembly, he received an engraved silver tray, a fishing rod, reel and other accessories, car clock, and an album containing many fine photographs of the hospital. Mrs. Gale received a rhinestone nd sapphire brooch. Members of the board of commissioners presented the retiring director with a radio and members of the Alumnae Association and student nurses gave him a variety of fishing tackle, as well as other fishing equipment. When he was the guest of honour at the hospital's medical society, Mr. Gale was presented with an easy chair.

Upon his retirement, Mr. Gale had been granted a six-month leave of absence and is now enjoying a well-deserved holiday. May the fishing be

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• Dr. Grant Colpitts of Halifax, N.S., commenced his new duties as pathologist at the Welland County General Hospital, Welland, Ont., on January 1st. Previously, the hospital had shared the services of a pathologist with other hospitals of the area.

• Allan H. McLean, who has been administrator of the Portage La Prairie General Hospital, Portage La Prairie, Man., since June, 1951, has accepted a position with the Misericordia Hospital, Edmonton, Alta.

• Sigmund Samuel has been elected president of the board of governors of the Toronto Western Hospital, Toronto, Ont., to succeed F. J. Coombs, who has been a member of the board for 27 years and president for the past eight years. Mr. Samuel has been a member of the board of governors for more than 40 years, and has been a vice-president since 1944.

• T. F. Kingsmill has been elected chairman of the board of trustees at the Victoria Hospital, London, Ont. He succeeds William Loveday who had been chairman for the past 14 years.

Fifth Annual Short Course in Hospital Housekeeping

The fifth annual short course in hospital housekeeping, again to be conducted by the American Hospital Association and Michigan State College on the campus at East Lansing, Michigan, will be held from April 6th to May 29. The eight-week session is designed to give basic training in hospital housekeeping. Subjects covered include bacteriology, housekeeping procedures, buying and maintaining supplies and equipment, general cleaning, and fire safety. Classes geared to train good supervisors — classes in personnel management and employee training — are offered in the course.

Ten scholarships are awarded each year by Pacific Mills. To become eligible for a scholarship, applicants need to submit only a statement on "why I am interested in hospital housekeeping as a career" and attach it to an official entry form. Further information may be obtained from the American Hospital Association, 18 East Division St., Chicago 10, Ill.

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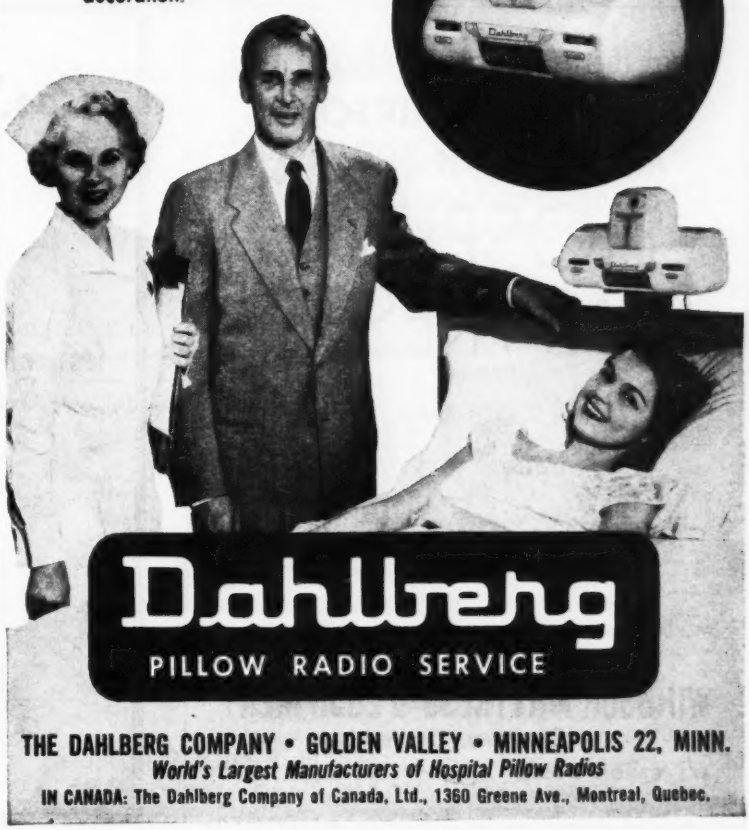

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Hospital Credit and Collections

(Continued from page 54)

cognized in business that there is a place for the printed notice and reminders as an assistance to the collection of unpaid accounts. These are sent after the account has reached the first stages of delinquency. Careful thought should be given to the style and the tone of the collection letter. Presuming that your files contain all the facts accumulated on the day of admission and during the period the patient was in hospital, and you have analyzed this data and know what is involved, a barrage of letters containing all the threats you can conjure up, will avail you little if you are not prepared to carry them out and act with authority. The purpose of a collection letter is to convey a thought that will lead to action by the receiver. The rules of importance in its composition are — know what you want to say and *say* it.

Always remember, a collection letter should be a collection letter — and not an academic exercise. If the debtor has assets and there is no dispute concerning the account, he will usually pay. You are merely trying to get action, now. He may pay because you threaten him at once; but a threatening letter is not the best. There are several appeals that may be used to better advantage that are not so embarrassing and reflect an atmosphere of dignity for the hospital.

1. Appeal first to fairness and honesty. A credit transaction is a mutual obligation that the hospital has done its part and the patient or guarantor should now do his.

2. Appeal to pride. Payment has not been made with the usual attention and promptness.

3. Appeal to self-interest. Speak of the probability of interest being added, and credit standing being impaired.

4. Appeal to fear. This is the strongest and final appeal, informing the debtor that unless attention is given, court action will be taken. It should be reserved as a last resort.

The volume of out-standing accounts sometimes makes it impractical to dictate special individual letters to each debtor. A collection letter manual can be used to advantage. The letters and paragraphs should be coded or indexed for ready reference. The credit manager may then denote by code the type of letter or paragraph he wants to be used. Some policy should be established with regard to the time interval between collection reminders. Sending notices too frequently is bad policy and loss of effectiveness results if too much time is allowed to elapse. Some hospitals send them out every two weeks.

It is well to remember that each account represents an individual and individuals should be dealt with on their own merits. For better results, then, each letter should be signed in ink by the credit manager or one in authority.

The telephone is one of the most effective means of collecting past due accounts. Every call obtains an answer of some kind, at least, and the success of the call depends largely on the skill and tact of the collector. An answer is received and forms the basis for further handling of the account, leaving little doubt as to what action to take. As the telephone is generally used when no reply has been received to letters sent, the debtor cannot lightly disregard it as he would a further letter. Quite often, a difficult debtor would like to give undue publicity to

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a letter written without due consideration; whereas the collector, in conversation, can fit in with the temperament of the debtor and phrase statements which, if written, would be resented. Speed is the essence of every call, with a marked saving in the expense of postage and stationery, to say nothing of the time saved in looking up files on the receipt of letters, and the reduction of the returned mail problem.

Because "there is a time and place for everything", the use of the telephone for collections should have its limitations. A telegram often proves an efficient method of collection through the medium of surprise. Discretion should be used, however, when employing this means of contacting delinquent debtors.

Personal contact has the advantage of providing a better opportunity of judging a person's circumstances and responsibilities and the ability to pay. Other advantages might include checking to see that statements and letters are being properly received; the detection of a change in position or of unemployment; a check on new addresses in "skip" cases; the convenience to the debtor in the personal call at the place of residence for payment, particulary, in the case of shut-ins.

The cost of maintaining this type of service is considerable but the results obtained and the good will created often warrants the expenditure made. In most hospitals, the personal contact is usually made through the medium of independent collection agencies and is a last resort. If such arrangements are made, careful investigation of the methods used by the agency should be made.

Even though considerable effort may have been expended in the collection of an account, it is well to assume that the debtor may have encountered difficulty in meeting his obligation. For this reason, an expression of appreciation should accompany the final payment and be personally signed.

It is well to bear in mind, always, in this business of credit and collections that the attitudes which make people like you, make people like the hospital. It is not so much in what you say but how you say it that matters. The kindness, thoughtfulness, courtesy, and sympathy extended and expressed in service to our fellow men will help improve the hospital's collections.

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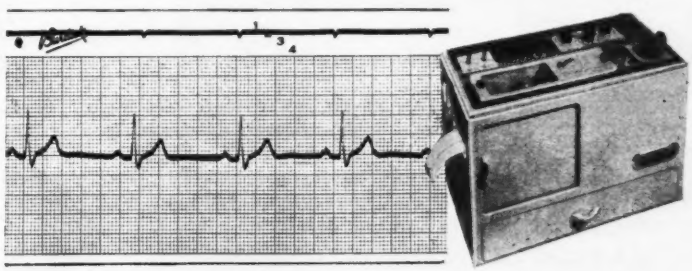

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This publication should aid administrators in new hospitals who must develop patterns for staffing the nursing department and should be equally useful as a measuring rod in established situations. Among subjects discussed in "Cues" are: factors affecting staffing patterns, the basis for estimating staff quotas, and establishing personnel quotas.

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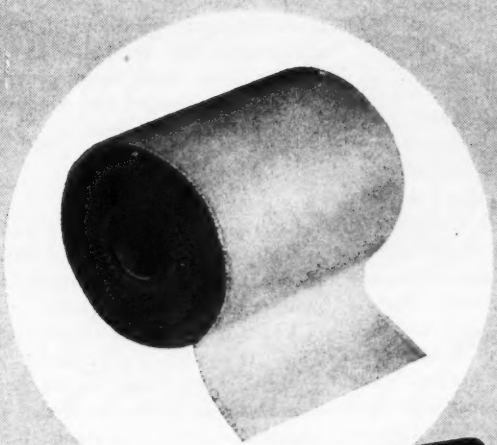

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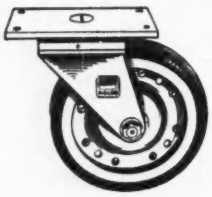

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Dietitians Can Help Diabetics

(Concluded from page 60)

psychology to encourage a taste for sweets which can never be naturally satisfied. If the patient will take his tea or coffee without sweetening for a week, he usually becomes accustomed to it. A few, however, will still prefer it sweetened. If so, do not make this an issue.

There are a number of firms who are still exploiting diabetics in the matter of so-called diabetic foods*. Soy-bean flour and bread are still being sold. Diabetic cookies and candies are still on the market. They are a snare and a delusion. While soy-bean flour is lower in carbohydrate, it is higher than wheat flour in protein and fat. The diabetic cookies and candies, if they taste right, are probably no lower in carbohydrate than the ordinary ones. If they are lower in carbohydrate, they are an insult to one's taste buds. There are two exceptions—D-Zerta and diabetic ginger ale. The first product is appetizing and the second compares favourably with the ordinary ginger ale, without its 10 per cent carbohydrate value.

In summing up, I would advise you to get acquainted with your diabetic patients. They are, for the most part, interesting people. Try and fit the diet into their accustomed eating habits in so far as you are able. The diet sheet should be as simple as possible, with simple substitutions in ordinary household measures. Stress with patients, first of all, the correct carbohydrate intake. Make it clear to them that they must always consider not only the type of food they eat but also the quantity they consume. The carbohydrate content of the diet should not vary from day to day. If the carbohydrate is, for instance, 160 grams for the day, those 160 grams make up their pay check and should be spent judiciously. If they insist on eating large quantities of bread, they cannot have fruit and vegetables. A very serious error can occur by using extra amounts of 20 per cent corn, while they will make no serious error with the 5 per cent vegetables. The protein intake I believe to be of less importance provided it is adequate. Rarely will the patient desire more than he is permitted. The amount of fat in the diet must be watched particularly in two classes of patient — those who are markedly overweight and those who are using a diet very high in carbohydrate. In both these classes of patient, the doctor has vigourously restricted their fat intake.

** The opinion expressed is that of the author and not necessarily held by all members of the C.D.A.*

Emotion is Energy

Emotion is energy. Don't waste it. It's silly to get angry over trifles and foolish to get over-enthusiastic about matters of small importance.

You can't live at full stretch all the time. If you try, you'll inevitably suffer from reaction and lose the pleasure your enthusiasms have produced. Every athlete knows the importance of relaxing after strain. It's as vital for minds as for bodies. — *Roffe Thompson in "John Bull"*

Obligations of a Doctor

To discontinue medical care when the patient leaves his bed and to fail to consider the social, psychological, and economic needs of the patient during his convalescence is to leave a major portion of the medical obligation unfulfilled. — *Frank H. Krusen, M.D.*

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Better Hospital Administration

(Concluded from page 76)

hold in Canada.

The need for some type of formal training for people already employed in hospitals throughout Canada has been known for some time. Most of these people are unable, for one reason or another, to leave their present employment to attend existing university courses. It was to meet this need that the Canadian Hospital Council inaugurated the extension course in hospital organization and management in the fall of 1951. The course is operated by the Canadian Hospital Council, with assistance on curriculum content and supervision contributed by the Department of Hospital Administration, University of Toronto, and financial assistance by the W. K. Kellogg Foundation.

The course is of two years' duration, each year consisting of a winter and a summer session. The winter sessions are conducted on a home-study basis, with lessons and assignments similar to the orthodox methods for conducting correspondence courses. At the summer session, the students are brought together to review the lesson material covered during the winter and to consider new areas of study. The faculty for the summer session is drawn from the Department of Hospital Administration, University of Toronto, and, as well, includes hospital administrators and senior department heads. This past year, we were exceedingly fortunate to have on our faculty for the Kingston session, Dr. A. C. Bachmeyer, former director of the University of Chicago's course in hospital administration. At Regina, we had Dr. Malcolm T. MacEachern, and James Stephan, associate director of the course in hospital administration of the University of Minnesota.

At the present time, we have almost 100 students enrolled in the course and they are located in every province of Canada. There has been a very enthusiastic demand for the course so far. Many applications are on hand now for the session commencing in the fall of 1953. However, as in the case of the program in British Columbia, it is too early to make a definite evaluation of this type of training.

Another project recently undertaken by the Canadian Hospital Council to promote better hospital administration is the production of the Canadian Hospital Accounting Manual. This manual was made possible by the co-operation of the Dominion Bureau of Statistics and the provincial governments.

The fact that I have limited my remarks to the formal training for better hospital administration does not in any way minimize the importance of institutes and other similar means of training. There is no doubt that for a few years to come, a great many of our administrators will continue to come up from the ranks. For those individuals who cannot or do not avail themselves of the normal programs now offered, well-organized institutes will prove invaluable. For those who have completed formal courses, institutes will be welcomed as refresher courses. Formal training and institutes go hand in hand in providing a means of qualifying hospital personnel to perform better the task of administering hospitals.

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Since our laundry got rid of 'soap-starved' washing formulas!
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by getting your washing formulas in "balance." Unbalanced, "soap-starved" formulas can't do a job for you. Better check the effectiveness of the soaps you are using now.

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Colgate's Arctic Syntex "M" leaves no hard water residue. Glasses and dishes dry sparkling clear. Instruments to be sterilized are spotless if washed in Syntex before sterilizing. Painted walls are easily and quickly washed with Syntex, without damage to the paint.

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Ship: ☐ 150 LB. TRIAL ORDER ☐ WORKING SAMPLE

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Book Reviews

(Concluded from page 72)

a distinct increase in the birth rate in the United States. Death rates appear to be increasing slightly in most European countries, an increase which may be attributed to the recurrence of influenza epidemics noted during the winter of 1950-51. World population is still increasing particularly in Egypt, Israel, Ceylon, Japan, the Netherlands, Yugoslavia, Finland, Australia, and New Zealand.

* * * *

"Hospital Talk"—a New Bulletin

An interesting, informative, and pleasingly-designed bulletin "Hospital Talk" is now being published, for distribution to Saskatchewan hospitals, by the division of hospital administration and standards, with the co-operation of the health education division, of the Department of Public Health, Regina. Articles of practical value to hospitals are contained in each issue, as well as current news about people and many helpful suggestions which will be useful to hospital personnel working in various departments.

An article by Robert M. Clements, accounting consultant of the division of hospital administration and standards, which appeared in the December issue, described a home-made medication cart used at Ste. Therese Hospital, Tisdale, Sask. This article is well-illustrated, points out the advantages of such a cart, and gives clear and concise directions on how to construct a similar piece of equipment. Currently, a series of articles are being run on adequate protection against fire. It is obvious that a great deal of thought and effort has gone into the planning of this bulletin and much of the material published in it will be of interest not only to the hospital people of Saskatchewan but all across the country.

* * * *

Staff News and Views at the Royal Victoria

Sprightly and interesting, both from the viewpoint of design and printed content, is the staff publication of the Royal Victoria Hospital, Montreal. The Christmas issue is gay with coloured illustrations, pictures, and line drawings. News about staff and their activities, and write-ups about various departments, are brief and deftly done. For putting their best foot forward in such an attractive way, congratulations are certainly in order for the staff of the Royal Victoria.

* * * *

Digest of American Health Programs

"Health Programs Digest", published by the U.S. Public Health Service, brings together in outline form, salient facts about organized programs for the provision of health services or for the payment of hospital and medical care costs, in the United States.

Mimeographed, with paper covers, "Health Programs Digest" is a Public Health Service Publication, Number 191. Further information can be obtained by writing to the Public Health Service Publications, Washington, D.C.

An exaggeration is a truth that has lost its temper.—*Kahlil Gibran*

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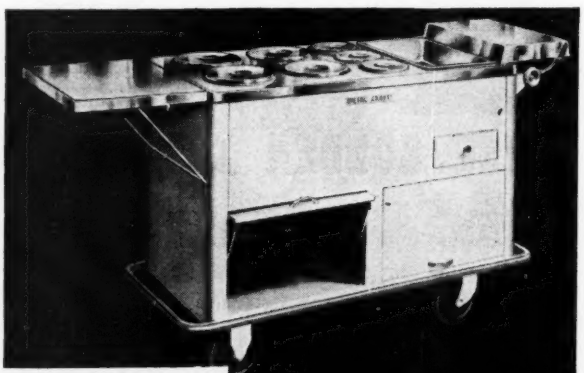
from Kitchen to bedside!

Metal Craft Food Conveyors bring, to even the most delicate bed-patient appetites, foods in a condition best calculated to appeal to them . . . piping hot, and with all their natural kitchen goodness preserved. Designed for automatic, temperature-controlled, flavour-saving food distribution, Metal Craft Food Conveyors are also built for long service, ease of handling and practicability. For complete information write:



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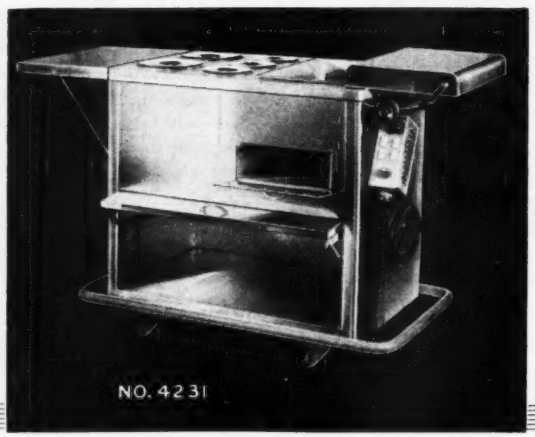

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The Food Clinic in Diet Therapy

The first food clinic in the world was established at the Boston Dispensary in 1918 by Frances Stern, a pioneer in the field of applied nutrition. Since that time other food clinics have been established throughout the United States, Britain, and Canada.

In 1949, a food clinic was established as a branch of the dietary department in the out-patient department of the Victoria General Hospital, Halifax, N.S. Its main purpose was to aid the clinic physicians in carrying out dietary treatment as a part of successful medical treatment. The clinic was staffed by a trained clinic dietitian. The emphasis of the food clinic runs the whole gamut of diet therapy and teaching — from planning relatively low cost diabetic diets to convincing a fisherman-farmer in servitude to duodenal ulcers that he can continue working and still have digestive calm.

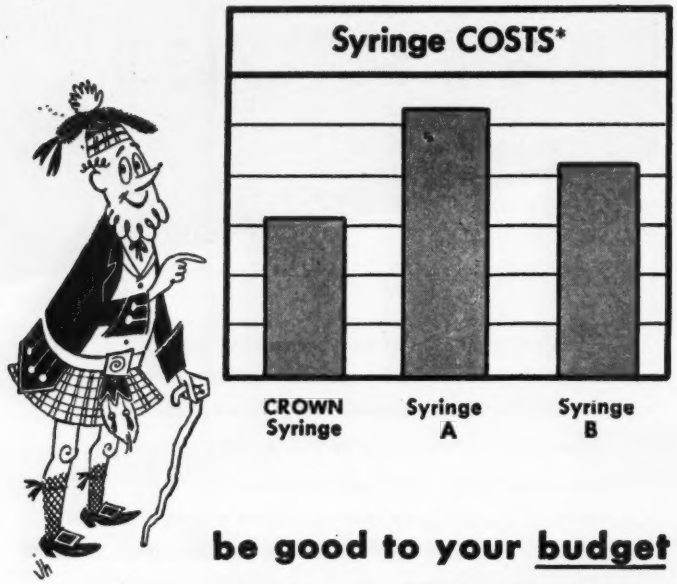
When a physician refers a patient to the food clinic, the dietitian interprets the prescribed diet to the patient in terms he can understand, explaining the need for the change in diet so that he will take greater interest in following it at home. Of necessity, the printed diet sheet is used. After the initial interview with the patient, the dietitian continues to teach the patient desired food habits. If possible an attempt is made to emphasize the need for good food for the patient's whole family, the cost of which must be within the income.

When an out-patient on dietary treatment is admitted to a hospital ward, the clinic dietitian passes on any pertinent information concerning that patient to the therapeutic dietitian. Also the clinic dietitian visits the patient in hospital. This is valuable both in strengthening a good relationship with the patient and in providing further knowledge of his progress when he returns to the out-patient department for a check-up after hospital discharge.

Accompanying the physicians on ward rounds is of three-fold benefit. The dietitian is prepared to sketch the pre-admission dietary treatment of the patients known to her. Conversely, during ward rounds she can establish contact with those patients whom the physician plans to refer to the out-patient department on discharge. As the clinic dietitian is also responsible for the instruction in nutrition and diet therapy of the fourth-year medical students, the discussion during ward rounds is of good practical value to them. By observing actual cases with the doctor in charge of treatment, it is impressed on the minds of these students that food control cures, as well as sustains, the body.

As an aid in assessing the patients' food habits a mimeographed food intake sheet was devised which, when folded twice, becomes a booklet with space to record three meals and any extra food taken each day for one week. When it is filled in and returned to the dietitian, it provides an excellent basis for personal instruction. Other teaching devices are few and simple in nature; a small block of

(Concluded on page 118)



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Penicillin Nonad Tulle is a gauze net of wide mesh impregnated with an emulsifying base containing 1,000 I.U. of Penicillin per gramme, equivalent to 160 I.U. penicillin per square inch of Tulle.

For use as a protective dressing to infected wounds and burns and as a first dressing following operations.

Supplied in sterile tins each containing 10 pieces 4″ x 4″, and in continuous strips 72″ x 4″.

Also Nonad Tulle available as sterile dressing *without penicillin* in following sizes: 2″ x 2″; 4″ x 4″; 6″ x 6″; continuous strip 4″ x 72″ and 3 continuous strips 4″ x 72″.

Complete literature on request.

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Food Clinic in Diet Therapy

(Concluded from page 116)

wood to illustrate the size of a square slice of commercial bread and one cut from a homemade loaf, as well as a variety of posters. Recently, through the kindness of the Nova Scotia Department of Education, film strips have been made available. These are as popular with the staff as they are with the patients and afford an excellent method of teaching.

No longer does an out-patient, having received treatment and care, return home in ignorance to those very conditions which caused him to become a patient. He is made acutely aware of the importance of food, of his responsibility, and of the willingness of the clinic to continue to help him, if he will help himself. The food clinic illustrates the practical application of dietetic principles to the ambulatory patient.—*Reprinted from Canadian "Nutrition Notes", October, 1952.*

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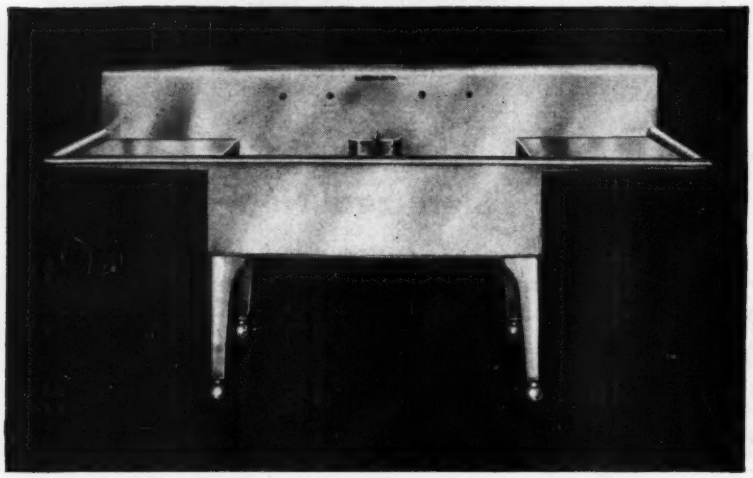

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Double compartment double drainboard sink as illustrated $295.00

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Medical Records Course

(Concluded from page 41)

Foundation, and administered through the Canadian Hospital Council offices, the educational standards, curriculum content, and granting of certificates are all by authority of the Canadian Association of Medical Record Librarians.

The class will be limited annually to some fifty people from across Canada who are able to avail themselves of this opportunity to improve their status in their chosen field of endeavour. It is anticipated that enrolment of the first class will begin in March for the academic year commencing in the fall of this year. Further details concerning the course and the necessary application forms may be obtained by writing to the Secretary, Committee on Education, Department "E", Canadian Hospital Council, 280 Bloor Street West, Toronto 5, Ontario.

More Schools of Practical Nursing Needed in the United States

An increase of at least 50 per cent in the number of officially approved schools of practical nursing in the United States is recommended in a report which was issued recently by the National Association for Practical Nurse Education. There is need also for greatly expanded staffs and facilities among existing schools in order to relieve the nation's serious nursing shortage, according to the report.

Including the 21 schools which have been added, during the past year, to the association's list of accredited schools, there are now 190 institutions that have been approved by the association and by state licensing agencies. These schools graduate approximately 9,000 students each year but there is a need for 60,000 practical nurse graduates annually. In order to meet this need, the United States should have 300 schools that can graduate 200 students a year.

Flow Varnish for Best Results

Varnish should be flowed onto a surface with a brush that holds as much material as possible without dripping. A small area should be quickly covered and the varnish spread out evenly. Brush across the grain and then lightly with the grain, using even strokes so as to obtain uniform thickness.—*Institutions Magazine*

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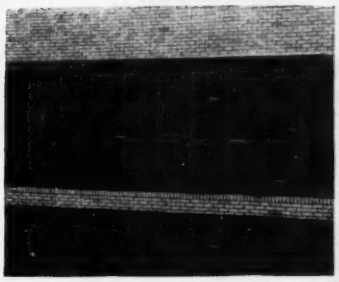

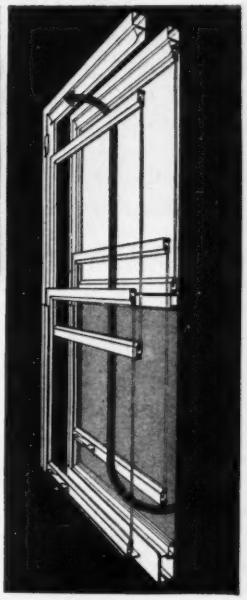

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GLASS • SCREEN (optional) • BUILT-IN WEATHER STRIPPING • WOOD or METAL SURROUND • INSULATING SASH (optional)

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A COMPLETE WINDOW UNIT

Factory-Painted Fully-Assembled Ready to Install

The Rusco Prime Window makes possible substantial savings in installation time, labour and maintenance. Because it is a fully-assembled, finished unit, it eliminates on-the-job glazing, refitting, painting and attaching of hardware. Used with insulating sash, it permits rainproof, draft-free ventilation in every kind of weather. All sash sections are removable from inside. Interchangeability of uniform sized extra sash simplifies replacement of broken glass. Reglazing is done quickly, easily in the maintenance shop. For details and name of your nearest distributor—write us.

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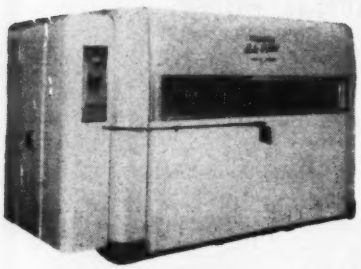
Medicine Advances in Ethiopia at the Princess Tsahai Memorial Hospital

Since its opening last year, the Princess Tsahai Memorial Hospital, Addis Ababa (see *The Canadian Hospital*, Sept. 1951), has done much to advance medical progress in Ethiopia. The hospital is dedicated to the memory of Princess Tsahai, daughter of Emperor Haile Selassie, who received her nurse's training in England and then returned to her homeland where she died in the service of others at the age of 23. It was built and equipped through the support of British subscribers.

Two operating theatres are now in use at the hospital, the laboratory is providing a service not hitherto possible in Addis Ababa, and a blood transfusion unit is being prepared. A radiologist and an anaesthetist have also been added to the staff. The School of Nursing for Ethiopian probationers is well furnished and equipped and has its full quota of students.

The Memorial Hospital Council in London which supports the hospital hopes to raise a fund for the assistance of destitute patients who are unable to contribute anything towards their treatment and who require help in various ways for their rehabilitation on leaving hospital.



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Emergency Feeding Methods

The importance of emergency feeding as a vital part of war and a great morale builder, was stressed by Edith Walker, director of Emergency Feeding, British Ministry of Food, when she addressed a recent conference held, in Ottawa, by the Civil Defence Welfare Division. Miss Walker stated that frequently the greatest burden of the emergency feeding falls on middle-aged women; men work at the heavier tasks of civil defence and young women are directed mainly into the services. Often the most necessary facilities for food preparation, such as electricity, gas, and water, are missing. Consequently, those engaged in emergency feeding are taught how to improvise by making use of bomb rubble, iron scraps, charred wood, and coal or coke which might be near at hand.

The British system concentrates on mobile equipment. Some units are capable of moving into a trouble area and serving approximately 8,000 light meals at a time.

Training School Director

Wanted, experienced Training School Director to inaugurate and administer new training school. Hospital—300 beds; new nurses' reisdence, beautifully furnished and equipped. Director will have full authority to commence School and future guidance. Apply to: Superintendent, Metropolitan General Hospital, Windsor, Ontario.

Laboratory Technician Wanted

For 177 bed hospital. Second Sr. Salary—$180.00 to $190.00 gross after 12 months. For full particulars write to (Miss) Noreen Flanagan, Administrator, Medicine Hat General Hospital, Medicine Hat, Alberta.

Assistant Dietitian Wanted

AN ASSISTANT DIETITIAN (Qualified)
For 200 bed Hospital.

Apply to Chief Dietitian, Prince Edward Island Hospital, Charlottetown, P.E.I.

Dietitian Wanted

For 177 bed hospital. Duties to commence immediately. Salary $200.00 to $220.00 gross after 12 months. For full particulars write to (Miss) Noreen Flanagan, Administrator, Medicine Hat General Hospital, Medicine Hat, Alberta.

Resident Dietitian

Dietitian required who will, under direction assume dietary responsibility at large Manitoba hospital. Must be graduate in dietetics from recognized university. Experience not essential. All statutory holidays observed, generous vacations with pay and other employee benefits. Suitable starting salary. Apply Sanatorium Board of Manitoba, 668 Bannatyne Avenue, Winnipeg.

Dietitian Wanted

Experienced dietitian required. Some experience in administration, therapeutic diets and teaching. Member C.D.A. Forty-hour week with one month holiday after one year. Apply Business Manager, Calgary General Hospital, Calgary, Alberta.

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Ferranti X-Ray Machine 1942 - 100 amp. model, complete. In good condition. Purchase price $3,300.00. Priced to sell. Write to secretary-treasurer, Vermilion Municipal Hospital, Vermilion, Alberta.

Dietitian Wanted

Dietitian wanted for Charlotte County Hospital. New hospital scheduled to open in the early Spring. Reply stating qualifications, experience and salary expected, to Superintendent, Charlotte County Hospital, St. Stephen, N.B.

Dietitian Wanted

An Assistant Dietitian (qualified) for two hundred twenty-five (225) bed hospital. Apply to Chief Dietitian, Moncton Hospital, Moncton, N.B.

Chief Laboratory Technician Wanted

Registered technician wanted for 200 bed General Hospital, Brandon, Manitoba, with expanding laboratory services directed by a Pathologist.

Apply through Office of Administrator, stating education, experience and references. Present salary range $2,880.00 to $3,000.00.

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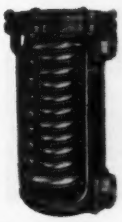

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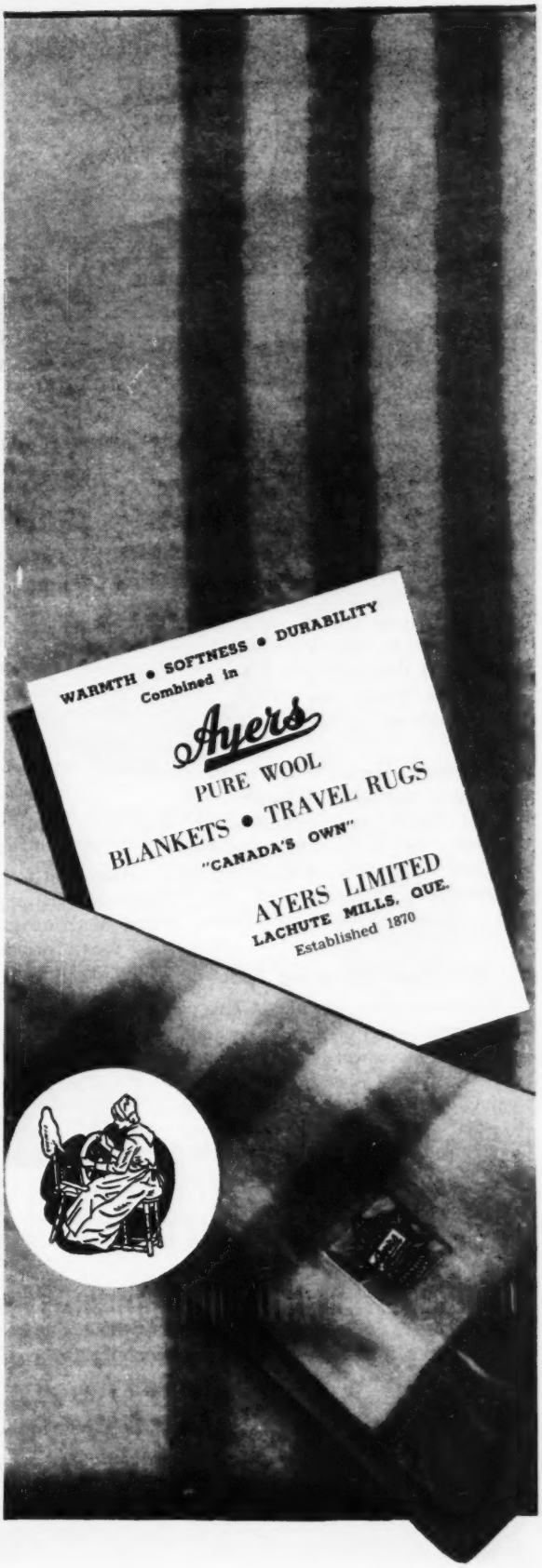


Mallinckrodt Staff Retirements

Mallinckrodt Chemical Works Ltd., Montreal, has announced the retirement of two of its officers who have served the company for more than thirty years.

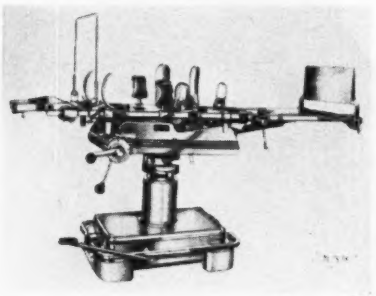
A. G. Pearson has retired from active service as Vice President, Secretary, and Director of the company. Herbert E. Potter has retired from active service as Treasurer and Director.

William R. Martin, Vice President, has been appointed Treasurer. H. Larratt Smith has been appointed Secretary, and A. K. Morgan becomes Assistant Secretary and Assistant Treasurer.

* * * *

New Ohio Operating Table

The anaesthetist can obtain any of 13 different surgical positions with a one-hand movement of the clutch while the patient is on the new A7100 major operating table manufactured by the Ohio Chemical & Surgical Equipment Co. (a division of Air Reduction Co., Inc), Madison, Wisconsin.



The "one-hand" feature permits the anaesthetist to keep his free hand on the patient at all times, thereby eliminating spark hazard caused by unequal electrostatic potential.

One lever quickly selects the desired position, then the crank is turned clockwise or counter-clockwise for Trendelenburg or horizontal movement. The meshing of gears is smooth at all times. Operation of the clutch does not interfere with the work of the surgeon or his assistant. A specially designed "toe-room" base is another new feature of the A7100 table.

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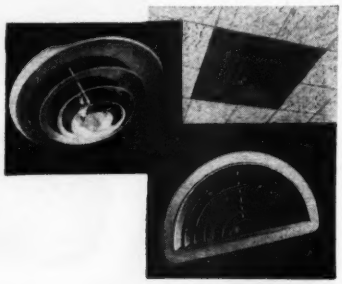
* * * *

Aspirating Air Diffusers

Anemostat Corporation of America announce the appointment of Control and Metering Limited, 2271A Bloor St. West, Toronto, as direct manufacturer's representatives for Ontario.



The Corporation manufactures a complete line of Anemostat Draftless Aspirating Air Diffusers. The correct type of Anemostat will give highly satisfactory results in the distribution of heating, cooling or ventilating air because of their scientific, tested designs.

Anemostats are made to harmonize with modern interior designs and are supplied, if desired, with a variety of circular or straight line lighting fixtures incorporated.

* * * *

Powerful Black Light Unit

Cooper Hewitt Electric Company, Hoboken, New Jersey, announces the development of a new and powerful black light unit in the 3660 angstrom range, a valuable tool in the fields of ophthalmology, pathology, mycology, and in dermatologic diagnosis.

A quartz high pressure mercury arc tube in a sealed beam is utilized to furnish the desired wavelength. Visible light is eliminated by a Corning filter, which transmits only the bands in the region of 3660 angstroms.

The swivel arm allows setting and adjustments of the lamp for practically all positions and directions. For mobility and ease of handling the lamp unit can also be disengaged from the power pack and held in the hand by means of the hand grip on the arm. An 8-foot extension cord for use between the lamp and power pack is supplied.

* * * *

Rogers Majestic T.V. Sets

Rogers Majestic Radio Corporation's television line for 1953 has been expressly designed for the Canadian TV market. Every known technical advance has been incorporated in their beautifully designed cabinets. Synchronized sight and sound is an exclusive feature in the table models, made possible by the speaker being mounted in the front of the receiver. The Electrostatic Tube

(Concluded on page 124)

A FEW OF OUR MANY HOSPITAL INSTALLATIONS

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Regina Grey Nuns Hospital

Saskatoon City Hospital

Saskatchewan Anti T.B. Sanatoria

Holy Cross Hospital (Calgary, Alta.)

University of Alberta Hospital

Aberhart Memorial Hospital (Edmonton, Alta.)

Vancouver General Hospital

Tranquille Sanatorium

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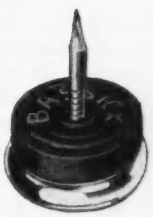
EASY ROLLING AND SWIVELLING QUIETNESS AND FLOOR PROTECTION

For old equipment or new, Bassick gives "full-floating" action. "DIAMOND-ARROWS", with high efficiency double ball bearing swivel construction, are built to give many years of economical, trouble-free service on all types of mobile hospital equipment.



Bassick's Rubber Cushion Glides — heavy-gauge, highly polished, nickel-plated steel base and live rubber cushion.

For peace and quiet in the wards
For easier moving, too,
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Can do the job for you.

SPECIFY BASSICK CASTERS AND GLIDES

Bassick SW

DIVISION
STEWART-WARNER CORPORATION
of Canada, Limited
BELLEVILLE ONTARIO

(Concluded from page 122)

and Cascade Tuner are two of many advances that produce a picture of unsurpassed richness, brilliance and clarity. Available in 17" and 21" screens, these Rogers Majestic models are strikingly designed in three hand rubbed veneers of walnut, mahogany and oak.

* * * *

West Companies Celebrate

Simultaneous employee parties at 22 of the West Disinfecting Company's 68 plants and district branches across the U.S. and Canada were held December 31st in honour of M. M. Marcuse, Chairman of the firm's Board of Directors. Mr. Marcuse, who is completing 50 years continuous service with the company, is one of the leading authorities in the field of sanitary chemicals. He is credited with many of the developments responsible for the industry's growth as well as the tremendous growth of the West Company.

Mr. Marcuse was made President of West in 1912 and Board Chairman in 1942. He was one of the founders of what is now the Chemical Specialties Manufacturers Association.

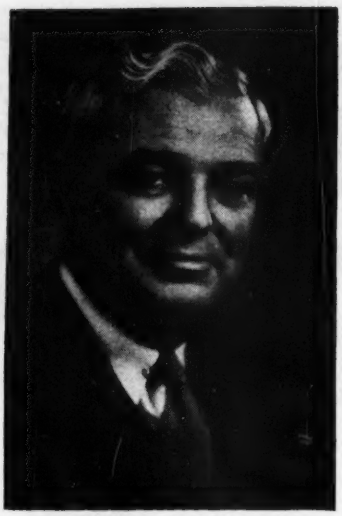
The company claims to be the originator of liquid hand soap, paper towels, and automatic dispensers for these materials, all of which have become standard safeguards of industrial and public health in the last 50 years. In addition to these products, the firm today manufactures insecticides, industrial insecticide dispensers, soaps and creams for preventing industrial skin diseases, industrial disinfectants, and a line of floor finishing and maintenance products.

* * * *

W. A. Duncan of Dominion Oxygen

William A. Duncan has been elected Vice-President and Director of Dominion Oxygen Company Limited, it has been announced by Thomas D. Cartledge, President. Mr. Duncan has been Sales Manager of Dominion Oxygen Company Limited for the past seven years.

Mr. Duncan was born in Sault Ste. Marie, Ontario, and was graduated from the University of Toronto with a B.A.Sc. degree in Civil Engineering. He joined the staff of Dominion Oxygen Company Limited immediately after his graduation in 1928, and had



William A. Duncan

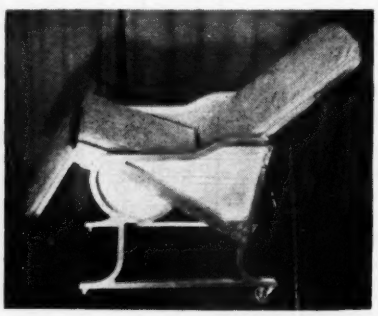
various assignments including that of Manager of Process Service, prior to his appointment as Sales Manager in 1945.

* * * *

New Stretcher-Chair Developed in Montreal

For over two years Dr. Harold Elliott and other specialists from the Department of Neurology and Neurosurgery of Queen Mary Veterans' Hospital, the Montreal General Hospital, McGill University, and the Research Division of the Robert Mitchell Company, Montreal, collaborated on the development of a mobile stretcher which could be quickly converted into a wheelchair designed for bedside nursing. The result of their efforts is the "Stretchair", a noiseless mechanical chair of polished aluminum and foam rubber upholstering.

Hospitals will find this wheelchair very practical in the nursing of paraplegics, cardiac cases, and most chronic invalids. It is stated that the "Stretchair" reduces the number of enemas required and practically abolishes the need for bed pans; it saves the time and work of the nursing staff, and means greater comfort for patients. It simplifies the moving of helpless patients to and from the operating theatre and x-ray department, and is useful for demonstrating patients in clinics.



"The Stretchair" measures six feet over-all. In the stretcher position it is twenty inches wide. In the sitting position, the seat drops to eighteen inches from the floor. The frame is of welded construction riding on five-inch diameter, ball-bearing, swivel wheels with foot locks. The foam rubber cushions are covered with sturdy fabricoid of good quality. Two handles, one on either side of the frame, are conveniently located. Thirty-five turns of the handle will raise or lower the chair from a sitting position (eighteen inches from the floor), at normal chair height, to a stretcher position at hospital bed height.

Hospital executives desiring more information about this equipment are invited to direct their enquiries to the manufacturers, The Robert Mitchell Co., Montreal.

* * * *

Angelica Surgeon's Gown

Angelica Uniform Company, marking its 75th anniversary as a manufacturer of hospital apparel, submits this illustration to show the progress made in surgeon gown design.

Thirty years of research and testing are represented by this modern Angelica surgeon's gown, combining comfort and durability. Functional designing includes: roomy raglan sleeves for flexibility of movement and absorbent snug-fitting double stockinette cuffs.

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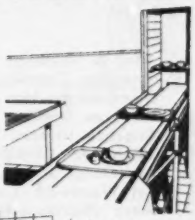

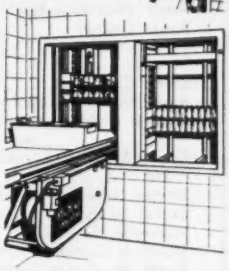

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